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Supreme Court, U.S.
FILED
071160 MAR 10 2008
OFFICE OF THE CLERK

No. 07-

IN THE

Supreme Court of the United States

EQUAL ACCESS FOR EL PASO, INC.
and PATRICIA DUARTE MELENDEZ,

Petitioners,

v.

ALBERT HAWKINS, COMMISSIONER OF THE TEXAS HEALTH AND HUMAN SERVICES COMMISSION, INDIVIDUALLY AND IN HIS OFFICIAL CAPACITY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. In consideration of the substantial conflict that exists amongst the circuit and district courts as to whether the Equal Access provision of the Medicaid Act confers individual private rights enforceable under § 1983, should this Court review this matter to ensure uniform interpretation of federal law and consistent application of its prior ruling in *Gonzaga University v. Doe*?

2. Given the unavailability of any administrative remedies to Medicaid recipients to address any violation of their rights to receive equal access to health care as secured to them by the Medicaid Act, and in consideration of the mandatory language of the Equal Access provision and the Congressional intent evidenced in the enactment of that statute, does the analysis required by *Gonzaga* nonetheless compel a finding that an individual right of action to enforce a violation of the Equal Access provision under § 1983 exists?

3. Does the Court's prior decision in *Wilder v. Virginia Hospital Association* compel a finding that Medicaid recipients have a right of action to enforce a violation of the Equal Access provision under § 1983 after *Gonzaga*?

PARTIES TO THE PROCEEDING

Petitioners are Equal Access For El Paso, Inc. ("Equal Access") and Patricia Duarte Melendez ("Melendez"). Equal Access and Melendez were plaintiffs in the trial court and appellees in the United States Court of Appeals for the Fifth Circuit. Initially, Ms. Melendez appeared in these proceedings not just on her own behalf, but also in her capacity as next friend of her minor child, Orandi Jahssar Melendez-Duarte ("Orandi"). However, Orandi died during the pendency of the case and a Suggestion of Death was filed in the trial court on August 31, 2005.

Respondent is Albert Hawkins, Commissioner of the Texas Health and Human Services Commission, individually and in his official capacity ("Hawkins"). Hawkins was a defendant in the trial court and appellant in the United States Court of Appeals for the Fifth Circuit.

Monica Rivero, as next friend of Kevin Rivero, Jessilyn Nagel, as next friend of Heidi and McKenna Armstrong, and Ruth Gallegos, in her individual capacity as next friend of Amber Gallegos, were plaintiffs in the trial court and appellees in the United States Court of Appeals for the Fifth Circuit, but do not join in this petition and will be served as Respondents.

El Paso County Hospital District, dba R.E. Thomason General Hospital, El Paso First Health Plans, Inc. ("El Paso First") and Jose Luna, Jr., M.D., were plaintiffs in the trial court, but the claims which they originally asserted in the trial court were not at issue in the appeal pending before the United States Court of Appeals for the Fifth Circuit, and they were thus not appellees in the court below and do not join in this petition.

RULE 29.6 CORPORATE DISCLOSURE STATEMENT

Equal Access For El Paso, Inc. ("Equal Access") files this Corporate Disclosure Statement pursuant to Rule 29.6 of the Rules of the Supreme Court of the United States and offers the following information in support thereof:

1. Petitioner Equal Access is a Texas not-for-profit corporation. It has no parent corporation. Because it issues no stock, no publicly held corporation owns 10 percent or more of its stock.

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The opinion of the United States Court of Appeals for the Fifth Circuit filed on December 10, 2007 in the case of *Equal Access For El Paso, Inc. v. Hawkins* is published at 509 F.3d 697 (5th Cir. 2007) and is reproduced in the Appendix at App. 1a.

The Opinion Granting In Part And Denying In Part Defendant's Amended Motion To Dismiss And Certification For Interlocutory Appeal of the United States District Court for the Western District of Texas, El Paso Division, filed on March 30, 2006, is unpublished and is reproduced in the Appendix at App. 16a.

BASIS FOR SUPREME COURT JURISDICTION

The United States Court of Appeals for the Fifth Circuit entered its judgment on December 10, 2007. App. 1a. No application for rehearing was filed. Petitioners seek review of the court's December 10, 2007 judgment on a writ of certiorari.

The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED IN THE CASE

The relevant statutes and regulations involved in the case are set forth below pursuant to Rule 14.1(f) of the Rules of the Supreme Court of the United States:

42 U.S.C. § 1320a-2:

> **42 U.S.C. § 1320a-2. Effect of failure to carry out State plan**
>
> In an action brought to enforce a provision of this chapter, such provision is not to be deemed unenforceable because of its inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan. This section is not intended to limit or expand the grounds for determining the availability of private actions to enforce State plan requirements other than by overturning any such grounds applied in Suter v. Artist M., 112 S. Ct. 1360 (1992), but not applied in prior Supreme Court decisions respecting such enforceability; provided, however, that this section is not intended to alter the holding in Suter v. Artist M. that section 671(a)(15) of this title is not enforceable in a private right of action.

42 U.S.C. § 1396a(a)(13)(A)(1992)(the "Boren Amendement")(repealed):

42 U.S.C. § 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

* * *

(13) provide—

(A) for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State which, in the case of nursing facilities, take into account the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this subchapter) of complying with subsections (b) (other

than paragraph (3)(F) thereof), (c), and (d) of section 1396r of this title and provide (in the case of a nursing facility with a waiver under section 1396r(b)(4)(C)(ii) of this title) for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care, and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1395x(v)(1)(G) of this title), for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1395x(v)(1)(G) of this title)) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic

> location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, nursing facility, and intermediate care facility for the mentally retarded and periodic audits by the State of such reports;
>
> * * *

Pub. L. No. 105-33, § 4711, 11 Stat. 251, 507-508 (1997) amended 42 U.S.C. § 1396a(a)(13)(A) above, which repealed the Boren Amendment.

42 U.S.C. § 1396a(a)(30)A:

> **42 U.S.C. § 1396a. State plans for medical assistance**
>
> **(a) Contents**
>
> A State plan for medical assistance must—
>
> * * *
>
> (30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan

(including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area; and

* * *

42 U.S.C. § 1983:

42 U.S.C. § 1983. Civil action for deprivation of rights

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in

such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

42 C.F.R. § 447.204:

Code of Federal Regulations

Title 42. Public Health

Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter C. Medical Assistance Programs

Part 447. Payments for Services

Subpart B. Payment Methods: General Provisions

§ 447.204 Encouragement of provider participation

The agency's payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

STATEMENT OF THE CASE

A. INTRODUCTION

As a result of the actions of defendant Albert Hawkins ("Hawkins") – who is the Commissioner of the Texas Health and Human Services Commission ("HHSC") – regarding the administration of the Medicaid program in the State of Texas, plaintiffs, including Petitioners herein, Equal Access for El Paso, Inc. ("Equal Access") and Patricia Duarte Melendez ("Melendez"), brought this action to enforce their rights under the Medicaid Act to receive adequate medical care through the Medicaid program administered by HHSC in El Paso, Texas.[1]

Petitioner Melendez is a Medicaid recipient seeking individual relief who is residing in El Paso.[2] She filed this lawsuit due to woefully inadequate reimbursement

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1. At the time this action was commenced, Melendez appeared not just on her own behalf, but also in her capacity as next friend to her minor child, Orandi Jahssar Melendez-Duar ("Orandi"). However, Orandi died during these proceedings and a Suggestion of Death was filed in the trial court on August 31, 2005.

2. In the district court proceedings, Melendez was one of several "Medicaid Recipient" plaintiffs to be named in this action, including Monica Rivero, as next friend of Kevin Rivero, Jessilyn Nagel, as next friend of Heidi and McKenna Armstrong, and Ruth Gallegos, in her individual capacity and as next friend of Amber Gallegos. Although these parties appeared in the district court and the appellate court proceedings below, they did not join in this Petition. To the extent that they may be referred to herein, these parties, together with Petitioner Melendez, are collectively identified as the "Plaintiff Recipients".

rates paid to Medicaid providers in El Paso, which force Medicaid recipients, including herself, to travel to other cities for care they are unable to receive in El Paso and to otherwise experience unreasonably long delays in receiving medical care because there is an inadequate supply of Medicaid providers in the El Paso area. She is joined in the proceedings below and in this Petition by Equal Access, a non-profit corporation formed to develop health care resources and equal access to health care in El Paso County. It has members who are Medicaid recipients who face the same types of problems and inequities faced by Melendez and the individual Plaintiff Recipients, all of whom have been adversely impacted by the actions of Hawkins (collectively, Melendez, the Plaintiff Recipients and Equal Access are identified as the "Medicaid Recipients").[3]

B. FEDERAL MEDICAID REQUIREMENTS

In 1965, the U.S. Congress enacted Title XIX, commonly referred to as the Medicaid Act, for the express purpose of funding health services for low income households. Unlike Medicare, Medicaid is a joint state and federal program in which each state voluntarily participates. The program is financed with a combination of state and federal dollars. To ensure continued participation in the Medicaid program, each state must adhere to the requirements within the federal Medicaid Act.

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3. In addition to the Medicaid Recipients, certain individual Medicaid providers (i.e., the El Paso County Hospital District, El Paso First Health Plans and Dr. Jose Luna) also participated as plaintiffs in this suit. However, the issues concerning those Medicaid providers were not before the appellate court below and they are not parties to this Petition.

Included within those requirements is a mandate that the state assure that payment rates to Medicaid health care providers are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. 42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. § 447.204. This provision is commonly known as the "Equal Access Provision". It was added to the Medicaid Act by amendment in 1989 for the purpose of preventing gross disparity between the availability of service to Medicaid patients and its availability to those who can afford to pay privately.

C. THE TEXAS MEDICAID PROGRAM

Medicaid in Texas is managed by HHSC, under the direction of its Commissioner, defendant Hawkins. In the El Paso area, HHSC conducts its Medicaid plan, in part, under a traditional "fee-for-service" program.[4] Through that program, physicians and other health care professionals are reimbursed by HHSC for the treatment of Medicaid recipients. HHSC establishes the rates of reimbursement for numerous different procedures, and these reimbursement rates apply statewide. As an example, if a physician in El Paso performs a simple delivery of a baby, she is reimbursed the same under the Medicaid fee schedules as a physician in Houston who performs the identical procedure.

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4. HHSC also operates a managed care program in El Paso, but that program is not significant to the issues raised in this Petition.

Plaintiffs allege in this proceeding that HHSC's fee-for-service rate schedules are woefully inadequate compared to the rates paid by both Medicare and private insurance for similar services.[5] App. 108a-109a. Indeed, plaintiffs allege that HHSC's fee-for-service Medicaid rates are almost 50 percent lower than rates paid for the same services by private insurance or Medicare. App. 124a-126a. Because of these inadequate reimbursement rates, many El Paso physicians limit the number of Medicaid recipients that they will provide services to. App. 122a-124a. Some refuse to participate in Medicare entirely. App. 122a-124a. As a result, Medicaid recipients do not have the same access to health care in the El Paso area as does the general population of that area. App. 121a-122a. For those same reasons, Medicaid recipients have to wait substantially longer for medical care than non-recipients in the El Paso area, which lacks sufficient health care providers such that the same amount, duration and scope of care and services available to Medicaid recipients are significantly inferior to those available to the general population. App. 122a-124a.

D. DISPOSITION OF THE CASE IN THE DISTRICT COURT

The Medicaid Recipients filed this suit against Hawkins to redress these violations of the Medicaid Act in the United States District Court for the Western District of Texas, El Paso Division, on October 23, 2003 and subsequently amended their complaint on June 24,

5. A copy of Plaintiffs' First Amended Complaint is set forth in the Appendix at App. 106a.

2004. App. 106a. Generally, plaintiffs alleged that HHSC's setting of inadequate and deficient Medicaid reimbursement rates denied the Medicaid Recipients in El Paso from obtaining adequate access to medical services in the El Paso area. App. 108a-109a. Plaintiffs' amended complaint sets forth eight separate claims for violations of the federal Medicaid Act (asserted under 42 U.S.C. § 1983) and violations of the Supremacy Clause and Equal Protection Clause of the U.S. Constitution. Included among those claims was an allegation, set forth at count one of plaintiffs' amended complaint, for a violation of the Equal Access Provision (42 U.S.C. § 1396a(a)(30)(A) and 42 C.F.R. § 447.204), claiming that the Medicaid reimbursement rates paid by HHSC in the El Paso area are deficiently priced and fail to enlist enough providers so that care and services are available to the Medicaid recipients residing in the El Paso area to the extent care and services are available to the general (non-Medicaid) population of the El Paso area. App. 132a-133a.

Hawkins subsequently moved to dismiss each of the claims brought by all plaintiffs, both under Rule 12(b)(1) and Rule 12(b)(6) of the Federal Rules of Civil Procedure – including the claims asserting a violation of the Equal Access Provision set forth in count one of the amended complaint. By its Opinion Granting In Part And Denying In Part Defendant's Amended Motion To Dismiss And Certification For Interlocutory Appeal rendered under date of March 30, 2006[6], the district court denied in part and granted in part that motion, ultimately dismissing

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6. A copy of the District Court's Opinion is set forth in the Appendix at App. 16a.

all of plaintiff's claims except with respect to those set forth in count one of the amended complaint. App. 103a-105a. Upon consideration of that claim, the district court instead denied defendant's motion to dismiss and held that the Equal Access Provision of the Medicaid Act creates a federal right in favor of Medicaid recipients that is enforceable under § 1983. App. 67a.

However, the district court agreed to certify two questions for interlocutory appeal pursuant to 28 U.S.C. § 1292(b): (1) whether the Medicaid Recipients had standing to bring their claims and (2) whether the Equal Access Provision of the Medicaid Act confers a private right of action upon the Medicaid Recipients. App. 102a-103a. The district court explained that it had upheld the Medicaid Recipients' claim under § 1983 for a violation of the Equal Access Provision based upon the controlling Fifth Circuit opinion in *Evergreen Presbyterian Ministries Inc. v. Hood*, 235 F.3d 908 (5th Cir. 2000), but believed that the Supreme Court's intervening decision in *Gonzaga University v. Doe*, 536 U.S. 273, 122 S. Ct. 2268, 153 L. Ed. 2d 309 (2002), merited review of the matter by the Fifth Circuit. App. 63a-67a. Defendant Hawkins thereafter sought an interlocutory appeal of that limited portion of the district court's Order denying its motion to dismiss, which the Fifth Circuit agreed to hear.[7]

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7. The Medicaid Recipients filed a Cross-Petition for Permission to Appeal, seeking to review the district court's dismissal of its other claims, but that request was denied by the Fifth Circuit.

E. PROCEEDINGS IN THE FIFTH CIRCUIT COURT OF APPEALS

After consideration of the matters presented to it on interlocutory appeal, the Fifth Circuit issued its Opinion under date of December 10, 2007. *See Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697 (5th Cir. 2007), App. 1a. The Fifth Circuit had little trouble in finding that the Medicaid Recipients had standing to enforce their claims ("We . . . have no difficulty concluding that the recipient plaintiffs have standing to assert their Equal Access provision claim". *Id.* at 701 n. 5, App. 8a.), but the court reversed the district court's denial of defendant Hawkins' motion to dismiss count one of the amended complaint, reasoning that *Gonzaga* compelled the Court to find that the Medicaid Recipients did not have a private right of action to enforce a violation of the Equal Access Provision under § 1983.

Applying *Gonzaga's* holding that "Section 1983 provides a remedy only for the deprivation of 'rights, privileges, or immunities secured by the Constitution and laws' of the United States", *Gonzaga*, 536 U.S. at 283, 122 S. Ct. at 2275, the Fifth Circuit held that the Equal Access Provision ". . . does not contain sufficient 'rights-creating' language critical to showing unambiguously the requisite Congressional intent to create individualized rights for Medicaid recipients and health care providers." *Hawkins*, 509 F.3d at 703, App. 12a. The Fifth Circuit thus found that *Gonzaga* abrogated its earlier holding in *Evergreen Presbyterian Ministries Inc. v. Hood*, 235 F.3d 908 (5th Cir. 2000), which had specifically upheld the right of Medicaid recipients

(but not providers) to bring an action under § 1983 to enforce a violation of the Equal Access Provision:

> We are forced by *Gonzaga* to abjure the notion that anything short of an unambiguously conferred private individual "right", rather than the broader or vaguer "benefits" or "interests," may be enforced under § 1983. Accordingly, we may not follow *Evergreen's* essential inference that, because Congress's aim in the Medicaid Act was to protect the interest of health care recipients as its primary, ultimate beneficiaries, Congress necessarily meant for recipients to enforce the Equal Access provision in private suits under § 1983.

Hawkins, 509 F.3d at 704, App. 13a-14a. Applying that rational, and reviewing the language of only the Equal Access Provision itself (and not any other relevant portions of the Medicaid Act), the Fifth Circuit concluded that the Equal Access Provision did not "necessarily" or "unambiguously" create private rights in recipients to enforce any violations of that statute by individuals under § 1983 – as the court felt it was constrained to find by *Gonzaga*.

In reaching that conclusion, the Fifth Circuit failed to take into account other statutory and jurisprudential authority that confirms that the Equal Access Provision ***does*** contain the "rights-creating" language required by *Gonzaga* to uphold a private right of enforcement under § 1983. The court also did not discuss the significant legislative history that confirms the intent of Congress

to create a private right of enforcement under § 1983 for the violation of the Equal Access Provision, the fact that Medicaid recipients have no other mechanism for the enforcement of their rights under this statute other than a § 1983 action, or the mandatory nature of the Equal Access Provision itself. Nor did the Court discuss (or, indeed, even barely mention) this Court's decision in *Wilder v. Virginia Hospital Association*, 496 U.S. 498, 110 S. Ct. 2510, 110 L. Ed. 2d 455 (1990), specifically upheld as valid law by *Gonzaga*, finding that a statute virtually identical to the Equal Access Provision ***did*** create private rights enforceable in a § 1983 action. And, although the Court noted decisions from other circuits also interpreting the Equal Access Provision under *Gonzaga*, the Court did not discuss the conflict the Fifth Circuit's decision in *Hawkins* creates with decisions from other circuit courts, or the inconsistency and confusion that persists amongst numerous federal courts in applying *Gonzaga* to the question of whether private rights are created by the Equal Access Provision.

For all of those reasons, Petitioners assert that the Fifth Circuit in *Hawkins* erroneously interpreted federal Medicaid law and that its decision creates and perpetuates a substantial conflict amongst the circuits and the district courts as to the question of whether a private right of action exits under § 1983 to enforce violations of the Equal Access Provision. Petitioners thus aver that this Court grant this Petition in order to correct these errors and provide clarification and direction with respect to the questions presented.

REASONS FOR GRANTING THE PETITION

A. CERTIORARI SHOULD BE GRANTED BECAUSE A SUBSTANTIAL CONFLICT EXISTS AMONGST THE CIRCUITS AS TO WHETHER THE EQUAL ACCESS PROVISION OF THE MEDICAID ACT CONFERS INDIVIDUAL PRIVATE RIGHTS ENFORCEABLE UNDER § 1983 UPON CONSIDERATION OF THIS COURT'S DECISION IN *GONZAGA UNIVERSITY v. DOE*

1. DESPITE *GONZAGA*, CONFUSION PERSISTS OVER WHETHER AN INDIVIDUAL PRIVATE RIGHT TO ENFORCE THE EQUAL ACCESS PROVISION OF THE MEDICAID ACT IS AVAILABLE UNDER § 1983

In the instant case, Petitioners aver that there is an existing split amongst the circuits on the question of whether or not the Equal Access Provision, 42 U.S.C. § 1396a(a)(30)(A), provides Medicaid recipients with a private right of action to enforce its terms under 42 U.S.C. § 1983. The Fifth Circuit's decision in *Hawkins*, which applied this Court's "rights-creating language" test from *Gonzaga*, held that the Equal Access Provision of the Medicaid Act does not confer individual private rights that are enforceable under § 1983. In so doing, the Fifth Circuit joined the First, Sixth, Ninth and Tenth Circuits who have also ruled post-*Gonzaga* in finding that the Equal Access Provision does not create enforceable rights under § 1983. *See Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.2d 50 (1st Cir.

2004)[8]; *Westside Mothers v. Olszewski*, 454 F.3d 532 (6th Cir. 2006); *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005); and *Mandy R. ex rel. Mr. and Mrs. R. v. Owens*, 464 F.3d 1139 (10th Cir. 2006). However, the Fifth Circuit decision in *Hawkins*, and those similar decisions from the First, Sixth, Ninth and Tenth Circuits, stand in sharp contrast to the Eighth Circuit, which held in *Pediatric Specialty Care, Inc. v. Arkansas Dep't of Human Services*, 443 F.3d 1005 (8th Cir. 2006), *cert. granted, judgment vacated in part sub nom. Selig v. Pediatric Specialty Care, Inc.*, 127 S. Ct. 1249, 167 L. Ed. 2d 74 (2007) that even after *Gonzaga*, the Equal Access Provision "creates enforceable rights" for recipients (and providers, as well) under § 1983.

As a review of these conflicting opinions confirm, the cases do not turn upon the unique facts and issues involved in each decision, but rather show a clear disagreement amongst the Fifth Circuit and its brethren, on the one hand, and the Eighth Circuit, on the other, in their respective interpretation of the federal statutes at issue, i.e., the Equal Access Provision and § 1983. This was exactly the type of confusion that *Gonzaga* was designed to resolve. In that case, various state and federal courts had divided on the question of the enforceability of the Family Educational Rights and Privacy Act of 1974 (FERPA) – the act at issue in

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8. In *Long Term Care*, the First Circuit addressed only whether providers – not recipients – of Medicaid services have a private right of action under the Equal Access Provision. *See Long Term Care*, 362 F.3d at 59. No Medicaid recipients brought suit in that case to enforce their rights under the Equal Access Provision, so the First Circuit did not make a decision based on facts similar to those now before this Court.

Gonzaga – under § 1983. The Supreme Court granted certiorari in *Gonzaga* ". . . to resolve the conflict among the lower courts and in the process resolve any ambiguity in our own opinions." *Gonzaga*, 536 U.S. at 278, 122 S. Ct. at 2272. However, despite the care of the *Gonzaga* court to provide direction and clarity on the question of when private rights are created by federal statutes, the existing split in the circuits upon consideration of whether private rights are created under the Equal Access Provision after *Gonzaga* best reflects the conflict and confusion that continues over the nature of a state's obligations under the Medicaid Act, and the availability of private enforcement for violation of rights created under that Act.

2. THE FIFTH CIRCUIT DECISION IN *HAWKINS* IS IN CONFLICT WITH DECISIONS OF THE 8TH CIRCUIT AND NUMEROUS DISTRICT COURT CASES INTERPRETING THE FEDERAL MEDICAID ACT

The Fifth Circuit in *Hawkins* held that the Equal Access Provision of the Medicaid Act does not confer individual private rights that are enforceable under § 1983. *Hawkins*, 509 F.3d at 703, App. 12a. The Fifth Circuit reached that conclusion by applying what it understood to be *Gonzaga*'s directive to look for "rights-creating" language in the Equal Access Provision critical to showing the requisite Congressional intent to create new rights. Upon conducting that exercise, the Fifth Circuit concluded that the Equal Access Provision did not contain sufficient "rights-creating" language critical to showing unambiguously the required Congressional intent to create individualized rights for Medicaid

recipients. *Id.* at 703, App. 12a. Because the Fifth Circuit believed that the Equal Access Provision has an aggregate focus ". . . that deals with institutional policy and procedures, rather than an individualized focus concerned with whether the needs of any particular person or class of recipients have been satisfied", *Id.* at 704, App. 14a, the Court, applying *Gonzaga*, held that no private right of action under § 1983 was available to the Medicaid Recipients to seek enforcement of that provision.

The Fifth Circuit's decision stands in marked contrast to the result reached by the Eighth Circuit in the case of *Pediatric Specialty Care, Inc. v. Arkansas Dep't of Human Services*, 443 F.3d 1005 (8th Cir. 2006), *cert. granted, judgment vacated in part sub nom. Selig v. Pediatric Specialty Care, Inc.*, 127 S. Ct. 1249, 167 L. Ed. 2d 74 (2007), interpreting the identical language in the Equal Access Provision reviewed by the *Hawkins* court, but with exactly the opposite result. In *Pediatric Specialty Care*, the Eighth Circuit addressed whether special needs children in Arkansas had a private cause of action to enforce their right to equal access to health care. *Id.* at 1008. After recognizing that the Court's prior decisions in the case pre-*Gonzaga* had upheld finding a § 1983 claim to enforce the Equal Access Provision, the Eight Circuit nonetheless took a fresh look at the question and held that "the plaintiffs still prevail within the terms of the *Gonzaga* analytical framework". *Id.* at 1015.

In reviewing that framework, the Eighth Circuit found it important that the Supreme Court upheld in *Gonzaga* its earlier decision in *Wilder* ("Although

Gonzaga takes a more restrictive view of rights-creating statutes, it did not overrule *Wilder*." *Id.* at 1015). *Wilder* similarly addressed the ability to enforce a subsection of § 1396a(a) through a § 1983 claim. Despite the fact that the Medicaid statute in *Wilder* did not explicitly state its intent to benefit health care providers, the Court there determined that the health care providers were the specific class of individuals protected under the statute. *Wilder*, 496 U.S. at 510, 110 S. Ct. at 2517-18. The Eighth Circuit similarly determined that although the Equal Access Provision does not explicitly state its intent to protect beneficiaries, there can be no doubt that Congress intended to protect those individuals by enacting the statute. *Pediatric Specialty Care*, 443 F.3d at 1015. Because the Equal Access Provision complies with the requirements laid out in *Gonzaga*, the Eighth Circuit thus concluded that it is enforceable through a private § 1983 claim.

As is clear from a review of *Pediatric Specialty Care*, the Eighth Circuit was fully informed regarding *Gonzaga* and relevant post-*Gonzaga* decisions. Well-aware of *Gonzaga*, and conducting an analysis of the issues before it under the standards announced in that decision, the Eighth Circuit nonetheless concluded that the Equal Access Provision created a right of action in favor of Medicaid recipients to enforce that provision through a § 1983 claim, holding "we do not read *Gonzaga* to require a different result than we reached in our earlier decisions." *Pediatric Specialty Care*, 443 F.3d at 1014.

The Fifth Circuit decision in *Hawkins* thus stands in direct conflict with the *Eighth Circuit* opinion in

Pediatric Specialty Care – both interpreting the identical language in the Equal Access Provision and both applying the same analysis as set forth in *Gonzaga*, yet each reaching an entirely different, and irreconcilable, conclusion. That result not only creates the type of "compelling reason" that this Court may consider to grant this Petition, as noted by Rule 10(a) of the Rules of the Supreme Court for the United States, but also perpetuates exactly the type of confusion that *Gonzaga* was intended to resolve. *Gonzaga*, 536 U.S. at 278, 122 S. Ct. at 2272.

Of course, this confusion is not limited exclusively to the circuit courts. Although *Pediatric Specialty Care* is the only circuit court case currently in direct conflict with the Fifth Circuit's decision in *Hawkins* (and the other circuit courts which the Fifth Circuit's decision followed), there are numerous federal district court cases from various circuits which have applied *Gonzaga* to find the existence of a right under § 1983 to enforce the Equal Access Provision. In *Clark v. Richman*, 339 F. Supp. 2d 631, 640 (N.D. Pa. 2004), a district court case arising out of the Third Circuit (which has yet to weigh in directly on the question of whether a private right of action under the Equal Access Provision exists post-*Gonzaga*), the court concluded that the Equal Access Provision "unambiguously confers private rights which are vindicable through *§ 1983*." *Id.* at 640. In reaching that conclusion, the court discussed *Gonzaga* and its application, but nonetheless reasoned that even under the analysis required by *Gonzaga*, the Equal Access Provision created a private right of action for its enforcement under § 1983. *Id.* at 639.

The district court in *Clark* relied, in part, on another district court case from the Seventh Circuit in the unreported decision of *Memisovski ex rel. Memisovski v. Maram*, No. 92 C 1982, 2004 WL 1878332 (N.D. Ill. Aug. 23, 2004)[9]. *Memisovski* involved a class represented by a group of plaintiffs who alleged, through § 1983, that Illinois violated, in part, the Equal Access Provision of the Medicaid Act. The *Memisovski* court engaged in an extensive *Gonzaga*-analysis, but nonetheless concluded that the Medicaid recipients **did** have a private right to enforce the Equal Access Provision under § 1983. *Id.* at *5-12. In response to the defendants claims in that litigation that the Equal Access Provision did not unambiguously demonstrate congressional intent to create rights, the court relied upon another portion of the federal Medicaid Act, 42 U.S.C. § 1320a-2, which provides that "an action may be brought to enforce another provision of this chapter," to find evidence of the intent of Congress not to eviscerate an otherwise enforceable right merely because it appears in a statute mandating that participating states include a particular provision in their state plan. *Id.* at *7. The Court also relied upon its observations that the Equal Access Provision is couched in mandatory language, contains no administrative mechanism for the enforcement of its provisions, and that the legislative history supports the notion that the Equal Access Provision provides for private actions, as evidence of the intent in the statute to create a private right of enforcement. *Id.* at *8. Finally,

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9. The Seventh Circuit, like the Third Circuit, has yet to directly consider whether, applying *Gonzaga*, a private right of action exists under § 1983 to enforce the Equal Access Provision. Similarly, the Second, Fourth and Eleventh Circuits have also not yet considered this question.

the Memisovski court also found significant the fact that *Gonzaga* specifically upheld as good law the Court's earlier decision in *Wilder* (which found a nearly identical Title XIX provision as creating private rights enforceable through § 1983) as further evidence that under the analysis set forth in *Gonzaga*, the Equal Access Provision created an enforceable, private right of action for Medicaid recipients under § 1983. *Id.* at **8-9.

Memisovski is one of a series of federal district court cases that continue to hold post-*Gonzaga* that the Equal Access Provision, even when examined under the analysis set forth in *Gonzaga*, nonetheless creates private rights and affords Medicaid recipients with a claim under § 1983 for enforcement of that provision. *See, e.g., Nelson v. Milwaukee County*, No. o4 C 0193, 2006 WL 290510 (E.D. Wisc. Feb. 7, 2006); *Ass'n of Residential Res. In Minnesota v. Minnesota Comm'r of Human Servs.*, No. Civ. 03-2438 (JRT/FLN), 2003 WL 22037719 (D. Minn. Aug. 29, 2003); *American Soc'y of Consultant Pharmacists v. Concannon*, 214 F. Supp. 2d 23 (D. Me. 2002). Indicative of the analysis applied by these courts is *Nelson*, which specifically discussed *Gonzaga* and its requirement to find evidence of "unambiguous intent to confer individual rights" for a statute to provide a basis for private enforcement, but, after such an analysis, nonetheless held that the Equal Access Provision did provide a private right of action for recipients of services under Medicaid. *Nelson*, 2006 WL 290510 at **10-12 (following *Memisovski* and its reliance on 42 U.S.C. § 1320a-2 and *Wilder*, among other considerations).

3. THIS COURT'S REVIEW IS NECESSARY TO ADDRESS THE INCONSISTENT INTERPRETATION OF THE EQUAL ACCESS PROVISION OF THE MEDICAID ACT RESULTING FROM THE DISAGREEMENT AMONGST THE CIRCUITS AS TO *GONZAGA'S* APPLICATION

These district court cases, along with the Eighth Circuit's decision in *Pediatric Specialty Care*, thus stand in sharp contrast to *Hawkins* and the other circuit court decisions in their interpretation of whether a private right under § 1983 exists to enforce a violation of the Equal Access Provision. Of course, they also differ dramatically in their application and analysis of *Gonzaga* to the federal Medicaid Act and the Equal Access Provision.

As a result, what these cases make clear is that, despite the intention of *Gonzaga* to clarify the analysis for determining when a private right of action exists in a federal statute, there remains much confusion and circuit conflict amongst the various federal courts over the nature of a state's obligations under the Medicaid Act and, specifically, over the question of whether or not a private right of action exists under § 1983 to enforce a violation of the Equal Access Provision. Even after *Gonzaga*, the circuit and district courts can't agree on a unified interpretation of the language in the Equal Access Provision to determine if a private right of enforcement under that act is available for Medicaid recipients under § 1983. And, although *Gonzaga* sought to implement a standard "rights-creation" test in the interpretation of whether federal statutes create private rights, the split amongst the circuits and the district

courts demonstrate that the various federal courts persist in applying the *Gonzaga* guidelines in a myriad of contrasting ways.

The effect of this approach is to not just produce inconsistent holdings amongst the circuits, but to generate and foster confusion as to the interpretation of federal laws that lead to uncertain and contrasting results. The Fifth Circuit's decision in *Hawkins* further compounds this problem by conflicting with the Eighth Circuit's ruling in *Pediatric Specialty Care* and differing in its approach and analysis of the Equal Access Provision from that undertaken by various other federal district courts from other circuits that have not yet addressed these issues. Because of these substantial inter-circuit disagreements over the interpretation of the Equal Access Provision and the confusion that remains as to the application of *Gonzaga* to address these fundamental issues arising under the Medicaid Act, this Court's review of this matter is not just appropriate, but mandated.

B. *HAWKINS* CONFLICTS WITH THE MEDICAID ACT'S EQUAL ACCESS PROVISION AND PRESENTS AN IMPORTANT QUESTION OF FEDERAL LAW THAT SHOULD BE SETTLED BY THIS COURT

1. *GONZAGA* CONFIRMS THE RIGHT OF MEDICAID RECIPIENTS TO ENFORCE THE EQUAL ACCESS PROVISION OF THE MEDICAID ACT THROUGH A § 1983 CLAIM

It is well settled federal law that a plaintiff may bring a § 1983 action against a person acting under color of state law to vindicate the deprivation of "any rights, privileges, or immunities secured by the Constitution and laws." 42 U.S.C. § 1983. The phrase "and laws" permits persons to sue for the violation of rights secured to them by federal statutes. *Maine v. Thiboutot*, 448 U.S. 1, 100 S. Ct. 2502, 65 L. Ed. 2d 555 (1980). However, § 1983 does not "provide an avenue for relief every time a state action violates a federal law" *City of Rancho Palos Verdes v. Abrams*, 544 U.S. 113, 125 S. Ct. 1453, 161 L. Ed. 2d 316 (2005). Instead, as the Court in *Gonzaga* noted, "it is rights, not the broader or vaguer 'benefits' or 'interests' that may be enforced under the authority of that section." *Gonzaga*, 536 U.S. at 283, 122 S. Ct. at 2275. Thus, a plaintiff seeking enforcement of § 1396a(a)(30)(A) must first establish that this provision "creates an individually enforceable right in the class of beneficiaries to which [they] belong." *City of Rancho Palos Verdes*, 544 U.S. at 120, 125 S. Ct. at 1458. If a plaintiff establishes that the statute creates a presumptively enforceable right, the defendant must then demonstrate that Congress has "specifically

foreclosed a remedy under § 1983" either expressly or impliedly, by creating a comprehensive enforcement scheme that is incompatible with individual enforcement under § 1983. *Blessing v. Freestone*, 520 U.S. 329, 341, 117 S. Ct. 1353, 1359, 137 L. Ed. 2d 569 (1997).

In *Blessing*, this Court set forth three requirements for establishing that a federal statute confers rights enforceable by § 1983:

> First, Congress must have intended that the provision in question benefit the plaintiff. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so "vague and amorphous" that its enforcement would strain judicial competence. Third, the statute must unambiguously impose a binding obligation on the States. In other words, the provision giving rise to the asserted right must be couched in mandatory, rather than precatory, terms.

Blessing, 520 U.S. at 340-41, 117 S. Ct. at 1359-1360 (citations omitted).

The *Gonzaga* case, handed down by this Court in 2002, provided further clarification on these prerequisites to finding the existence of a § 1983 claim to enforce a federal law. In *Gonzaga*, this Court acknowledged the continuing relevance of the *Blessing* test to "guide judicial inquiry into whether or not a statute confers a right." *Gonzaga*, 536 U.S. at 282, 122 S. Ct. 2275. The Court then clarified the first of *Blessing's* three requirements, making clear that only

unambiguously conferred rights, as distinguished from mere benefits or interest, are enforceable under § 1983. *Id.* at 282-83, 122 S. Ct. at 2277. The appropriate inquiry, therefore, is "whether or not Congress intended to confer individual rights upon a class of beneficiaries." *Id.* at 285, 122 S. Ct. at 2268. Critical to this inquiry is whether the pertinent statute contains "rights-creating" language that reveals congressional intent to create an individually enforceable right. *Id.* at 287, 122 S. Ct. at 2268.

Gonzaga most certainly did not foreclose private causes of action based on federal statutes – and it certainly did not preclude a private cause of action based on the Equal Access Provision. It simply clarified the first element of the *Blessing* test, to be sure that the focus of that inquiry was directed not just to a determination as to whether a plaintiff was a member of a group generally benefited by a statute, but rather, was the statute "phrased in terms of the persons benefited". *Id.* at 284, 122 S. Ct. at 2275. Thus, *Gonzaga* requires close attention to the wording and structure of a statute to determine whether Congress has created an individual entitlement that may give rise to a claim under § 1983.

a. THE MEDICAID ACT CONTAINS "RIGHTS-CREATING" LANGUAGE REQUIRED BY GONZAGA

The specific provision of the Medicaid Act at issue in this case provides:

> A State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. § 1396a(a)(30)(A).

In examining this language to determine if it creates enforceable rights under the first *Blessing* test, as clarified by *Gonzaga*, it is critical to review another provision of the federal Medicaid Act as well, 42 U.S.C. § 1320a-2, which provides:

> **In an action brought to enforce a provision of this chapter, such provision is not deemed unenforceable because of its inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan.** This Section is not intended to limit or expand the grounds for determining

> the availability of private actions to enforce State plan requirements other than by overturning any such grounds applied in *Suter v. Artist M.*, 112 S. Ct. 1360 (1992), but not applied in prior Supreme Court decisions respecting such enforceability; provided, however, that this section is not intended to alter the holding in *Suter v. Artist M.* that section 671(a)(15) of this title is not enforceable in a private right of action.

42 U.S.C. § 1320a-2. (emphasis supplied). This section was passed in 1994 after this Court's decision in *Suter v. Artist M.*, 503 U.S. 347, 112 S. Ct. 1360, 118 L. Ed. 2d 1 (1992). The Court in *Suter* held that § 671(a)(15) of the Adoption Act was unenforceable by a private person in part because that section merely required states to have a plan that contained a specific provision requiring states to make certain reasonable efforts. *Id.* at 358-59, 112 S. Ct. at 1367-68. As the clear language of § 1320a-2 confirms, it was enacted, at least in part, to specifically overrule *Suter* and to clarify the intent of Congress to not have a Medicaid provision deemed unenforceable simply because it happened to contain language as to what a state plan must include. "[T]he fairest reading of Section 1320a-2 is that Congress was concerned only that a court should not eviscerate an otherwise enforceable right merely because it appears in a statute mandating that participating states include a particular provision in their state plans." *Messier v. Southbury Training Sch.*, 916 F. Supp. 133, 144 (D. Conn. 1996).

In view of the specific dictate set forth in § 1320a-2, when applying *Gonzaga* to the Equal Access Provision,

a court should thus not consider that an individual entitlement is absent simply because the wording of the statute is directed to the required contents of a state plan as opposed to the rights of a beneficiary or provider under a plan. Clearly, provisions that require certain contents in state plans can create rights enforceable under § 1983, so long as they otherwise meet the test employed in this Court's *Blessing* and *Gonzaga* decisions. *See, e.g., Clark*, 339 F. Supp. 2d at 639 (relying on § 1320a-2 to conclude that a court should not consider that an individual entitlement is absent simply because the statute is directed to the required contents of a state plan); *Memisovski*, 2004 WL 1878332 at **7-8 ("Based on § 1320a-2, § 1396a(a)(30)(A) will not be deemed unenforceable simply because it only elaborates on what a state plan must include); *Nelson*, 2006 WL 290510 at *11 (finding that the Equal Access Provision creates a private right of action for Medicaid recipients in a post-*Gonzaga* analysis and relying, in part, on § 1320a-2); *Rabin v. Wilson-Coker*, 362 F.3d 190, 201-202 (2nd Cir. 2004)(in an action brought under a separate portion of the Medicaid Act, noting that § 1320a-2 "precludes defendant from relying on the plan requirement language of Section 1386r-6" to support claim that no enforceable rights were present in that statute)[10].

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10. *Rabin* is illustrative of the importance of § 1320a-2 to an analysis under *Gonzaga* as to whether a statute creates a right of enforcement under § 1983. In *Rabin*, the defendant argued that because the statute at issue focused on aggregate requirements incumbent on various administrative actors under a State plan (and not on the individual rights of the recipients the statute was intended to benefit), *Gonzaga* precluded finding that a private right existed. The 2nd Circuit, however, found that

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Viewed within this context, the Equal Access Provision clearly contains the "rights-creating" language required under *Gonzaga*. The plain language of § 1396a(a)(30)(A) clearly conveys that "A State plan . . . must provide" certain "methods and procedures" to ensure that "care and services" under the plan are readily available to Medicaid recipients to the same extent that they are available to the general population in a geographic area. As § 1320a-2 confirms, simply because the wording of this statute may be directed to the required contents of a state plan does not preclude finding that it also creates an enforceable right of action under § 1983.

Even if the language in the Equal Access Provision may not be similar to typical rights-creating language found in other statutes, for example, as in Title VI of the Civil Rights Act, that fact should not preclude the existence of a private right of enforcement. Courts have noted in the past that it is "difficult, if not impossible, as a linguistic matter, to distinguish the import of the relevant Title XIX language – "A State plan must provide" – from the "No person shall" language of Titles VI and IX." *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 190 (3rd. Cir. 2004). And the very structure of the

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§ 1320a-2 specifically precluded defendant from relying on the plan requirement language to deny its intent to create a private right otherwise enforceable under § 1983. Fully cognizant of *Gonzaga* – and applying its test – the *Rabin* court nonetheless concluded that § 1320a-2 precluded any finding that the aggregate language of the statute foreclosed the existence of a private right of enforcement under § 1983. *Rabin*, 362 F.3d at 201-202.

Medicaid Act and § 1396a(a), which sets forth the list of requirements that a state plan under Medicaid must meet, largely has prevented Congress from using the sort of "no person shall" language relied upon by the *Gonzaga* court in its review of the specific federal statute then before it, the Family Educational Rights and Privacy Act of 1974 (FERPA). Indeed, "it is precisely this structure – a provision's inclusion as a requirement of a state plan – that Congress, in § 1320a-2 . . . , directed the courts to ignore when determining whether the provision creates an enforceable right under § 1983" *Clayworth v. Bonta*, 295 F. Supp. 2d 1110, 1122 (E.D. Cal. 2003), reversed 140 Fed. Appx. 677 (9th Cir. 2005)[11]. As another court has noted, "That would, perhaps, be why Congress enacted § 1320a-2, to ensure that direction

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11. The district court's decision in *Clayworth* was subsequently reversed by the Ninth Circuit when it issued its opinion in *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005) holding that there was no private right of action to enforce the Equal Access Provision. *Sanchez*, however, did not discuss *Clayworth*, although it did note its belief that § 1320a-2 did not change the "general framework . . . used to analyze private rights of action under § 1983". *Id.* at 1057. Instead, the *Sanchez* court said that it was "bound to follow . . . *Blessing* and *Gonzaga*" and reached its conclusions without further reference to the import or application of § 1320a-2. In so doing, the Ninth Circuit placed itself squarely at odds with the Second Circuit, which the year before in *Rabin* had specifically considered and applied § 1320a-2 in upholding a private right of enforcement under a different portion of the Medicaid Act, as it believed it was required to do under *Gonzaga*. *See Rabin*, 362 F.3d at 201-202. As noted herein, numerous federal courts besides the Second Circuit have also considered and applied § 1320a-2 to a post-*Gonzaga* analysis and the fact that the *Sanchez* court chose not to do so is hardly determinative of its relevance to this analysis.

to include certain provisions in a state plan does not preclude a private action enforceable under § 1983". *Memisovski*, 2004 WL 1878332 at *8.

Thus, the Equal Access Provision complies with the "rights-creating language" prerequisite in *Gonzaga* to create a right to enforce it through a § 1983 claim.

b. THE EQUAL ACCESS PROVISION CONFERS RIGHTS ON A PARTICULAR CLASS AND IS MANDATORY

The Supreme Court also recognized in *Gonzaga* that in order to confer a private right of enforcement, a statute needed to "confer rights on a particular class of persons". *Gonzaga*, 536 U.S. at 285, 122 S. Ct. at 2276. The Equal Access Provision satisfies this test. In clear language, it focuses on a separate class of individuals to which the statute applies. It requires states to provide methods and procedures for payment of care and services in a manner that ensures equal access to quality care for Medicaid recipients. § 1396a(a)(30)(A). Under any set of circumstances, the beneficiaries are the recipients of the services to be provided under the state plan. As the Eighth Circuit confirmed in upholding a private right to enforce this provision, "The statute is clear on its scope: to ensure payments are not too high, but yet high enough to secure the participation of enough [providers] so that [recipients] receive equal access to quality health care". *Pediatric Specialty Care*, 443 F.3d at 1015-1016

It is also readily apparent that the Equal Access Provision is couched in mandatory language ("A State plan . . . must provide . . .), so that the state "must" have a plan that affords equal access. Significantly, the requirement of equal access set forth in § 1396a(a)(30)(A) is not phrased in indirect terms "such as requiring a general policy or requiring substantial compliance". *Memisovski*, 2004 WL 1878332 at *8 (quoting *Clayworth*, 295 F. Supp. 2d at 1123). As observed by *Clayworth*, if the statutory section were phrased indirectly or in more general terms (such as was the case in *Gonzaga*), "that might suggest that no single beneficiary is entitled to quality care or equal access." *Clayworth*, 295 F. Supp. 2d at 1123; *Memisovski*, 2004 WL 1878332 at *8; *see Nelson*, 2006 WL 290510 at *11. Instead, the requirements of equal access are phrased in mandatory and not precatory language. *See Sabree*, 367 F.3d at 190. States clearly "must" have a plan that affords equal access and there can be no dispute that the access provisions directly benefit recipients. *See Pa. Pharmacists Ass'n v Houstoun*, 283 F.3d 531, 537 (3rd Cir. 2002)(en banc).

Furthermore, the federal regulation implementing the Medicaid Act makes it clear the Medicaid recipients are the intended beneficiaries of the Equal Access Provision. "The agency's payments must be sufficient to enlist enough providers so that services under the plan are available to **recipients** at least to the extent that those services are available to the general population." 42 C.F.R. § 447.204 (emphasis supplied). Courts are to give considerable weight to an executive department's construction of a statute because of their expertise in the respective area. *Chevron U.S.A, Inc. v. Natural Res.*

Def. Council, Inc., 467 U.S. 837, 843, 104 S. Ct. 2778, 81 L. Ed. 2d 694 (1984). When a federal statute itself confers a right upon the plaintiff, and a valid regulation further defines or fleshes out the content, then the statute and regulation jointly may create a federal right as further defined by the regulation. *Bryson v. Shumway*, 177 F. Supp. 2d 78, 92 (D.N.H. 2001), *vacated on other grounds*, 308 F.3d 79 (1st Cir. 2002). This Court should therefore defer to the federal regulations, which recognize the clear intent of Congress that the Medicaid recipients within a geographic area be the beneficiaries of the Equal Access Provision.

c. MEDICAID RECIPIENTS HAVE NO MECHANISM OTHER THAN A § 1983 CLAIM TO ENFORCE THEIR RIGHT TO EQUAL ACCESS TO HEALTH CARE

Equally important, the Medicaid Act does not provide Medicaid recipients any enforcement mechanism to enforce the Equal Access Provision, a factor weighing in favor of finding the existence of a § 1983 claim. *Gonzaga*, 536 U.S. at 289-90, 122 S. Ct. 2278-79. In *Gonzaga*, this Court found support for the lack of a § 1983 claim to enforce FERPA because Congress had expressly provided other mechanisms for enforcing these provisions. *Id.* at 289-90, 122 S. Ct. 2278-79. Specifically, individuals suspecting a violation of FERPA could file individual written complaints, which initiated an investigation by the Secretary of Education and, if a violation was found, required affirmative steps by the violating institution. *Id.* at 289-90, 122 S. Ct. 2278-79.

This Court then distinguished that case from other instances when an aggrieved individual lacked any federal review mechanism. *Id.* at 289-90, 122 S. Ct. at 2278-79. Importantly, the *Gonzaga* court recognized that in its earlier decision in *Wilder*, which upheld health care providers' private enforcement of the Medicaid Act through a § 1983 claim, the statute involved in that case (the Boren Amendment) lacked this federal review process. *Id.* at 289-90, 122 S. Ct. at 2278-79. Similarly, the Medicaid Recipients in this case lack a federal review mechanism to otherwise enforce their right to equal access to health care. There is positively no suggestion here that administrative procedures exist through which recipients can seek equal access to health care. Because no administrative remedy was formulated to ensure compliance with this provision, a § 1983 claim is not just warranted, but is likely the only method available of ensuring compliance with the obligation to provide equal access to health care set forth in § 1396a(a)(30)(A).

2. *WILDER v. VIRGINIA HOSPITAL ASSOCIATION* REMAINS CONTROLLING AUTHORITY TO CONFIRM THAT A § 1983 CLAIM EXISTS TO ENFORCE THE EQUAL ACCESS PROVISION OF THE MEDICAID ACT

This Court has already found that language virtually identical to that set forth in the Equal Access Provision creates enforceable rights under § 1983 in the seminal case of *Wilder v. Virginia Hospital Association*, 496 U.S. 498, 110 S. Ct. 2510, 110 L. Ed. 2d 455 (1990). That case was not overruled by the *Gonzaga* court and remains controlling authority today. Its holding confirms that a private right of action under § 1983 is available and authorized to enforce the Equal Access Provision.

a. *WILDER'S* FINDING THAT A § 1983 CLAIM LIES TO ENFORCE THE BOREN AMENDMENT ALSO APPLIES TO THE EQUAL ACCESS PROVISION OF THE MEDICAID ACT

In *Wilder*, this Court considered whether the now repealed Boren Amendment conferred enforceable rights on medical providers. The specific portion of the Boren Amendment at issue in *Wilder* provided as follows:

> A State plan for medical assistance must –
>
> * * *
>
> Provide ... for payment ... of the hospital services, nursing facility services and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates ... which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal law, regulations and quality and safety standards, and to assure that individuals eligible for medical assistance have reasonable access ... to inpatient hospital services of adequate quality.

42 U.S C. § 1396a(a)(13)(A) (1982 ed. Supp. V) (repealed by Pub.L. No. 105-33, § 4711, 11 Stat. 251, 507-508 (1997))

The *Wilder* court concluded that this statutory language did confer enforceable rights under § 1983 on medical providers because (1) it was cast in mandatory rather than precatory terms and (2) the receipt of federal funds was expressly conditioned on compliance with the statute. *Id.*, at 512, 110 S. Ct. at 2518-19. Even though *Wilder* was decided long before *Gonzaga*, the Court therein cautioned that "[s]ection 1983 speaks in terms of 'rights, privileges, or immunities,' not violations of federal law", *Id.* at 509, 110 S. Ct. at 2517 – as *Gonzaga* subsequently noted – and the *Wilder* court took pains to analyze the statutory provision in detail, in light of the entire legislative enactment, to determine whether the language in question created an enforceable right of action within the meaning of § 1983.

The petitioners in *Wilder*, in challenging the existence of a § 1983 claim, argued that the Boren Amendment was too vague and amorphous to be judicially enforceable. *Id.* at 519, 110 S. Ct. 2522. Contrary to their argument, this Court determined that because the statute required the State, in making its findings, to judge the reasonableness of its rates against the objective benchmark of an efficiently and economically operated facility, the Boren Amendment was sufficiently definite to warrant a judicial remedy. *Id.* at 519-20, 110 S. Ct. 2523.

The Equal Access Provision likewise includes an objective benchmark by which States can measure whether their Medicaid programs provide recipients with equal access to health care. Recipients must have access to services equal to that of the general population within a geographic area. § 1396a(a)(30)(A). As in *Wilder*,

although there may be a range of access to health care sufficient to meet this standard based on how access is calculated, there certainly are some levels of access to health care that no State could ever find to be sufficient under the Act. *See Wilder*, 496 U.S. at 519-20, 110 S. Ct. at 2523. As *Wilder* concluded with respect to the Boren Amendment, it applies with equal consideration here, that the Equal Access Provision is not so vague and amorphous such that HHSC could avoid enforcement of it by the judiciary.

It is hard – if not impossible – to distinguish the analysis undertaken by *Wilder* of the language of the Boren Amendment from that required upon a review of the Equal Access Provision in this matter. The structure and language of the two statutes are nearly identical and each focuses on mandatory obligations a state plan must meet. Obviously, the *Wilder* court found that the Boren Amendment – virtually identical to the language of the Equal Access Provision – contained sufficient language to create an enforceable right of action under § 1983 and it is difficult to conceive how the Equal Access Provision would not, also, create such a private right of action for its enforcement. As some of the federal district courts considering this question have noted, "[if] a private right of action was allowed in *Wilder*, there is no principled basis to say that a private right of action [under § 1396a(a)(30)(A)] is unlawful." *Nelson*, 2006 WL 290510 at *11; *Memisovski*, 2004 WL 1878332 at *8.

b. *GONZAGA DID NOT OVERRULE WILDER*

As *Gonzaga* made clear, the decision in *Wilder* remains good law today. In *Gonzaga*, the Court made clear that it was *not* overruling *Wilder*. Instead, it held that *Wilder* was "squarely distinguish[able]" from the situation it was addressing regarding the private enforcement of FERPA. *Gonzaga*, 536 U.S. at 289-90, 122 S. Ct. at 2279. *Gonzaga* addressed an entirely different issue: whether a student may sue a private university though a § 1983 claim to enforce provisions of the Family Educational Rights and Privacy Act of 1974 (FERPA). *Id.* at 276, 122 S. Ct. at 2271. FERPA is far-removed from the Medicaid Act at issue in this case. This Court in *Gonzaga* expressly distinguished its decision in *Wilder* (where it had addressed a Medicaid statute virtually identical to all relevant parts of the statute at issue in this case) and expressly declined to overrule it. *Id.* 536 U.S. at 289-90, 122 S. Ct. at 2279. In doing so, the *Gonzaga* court obviously felt that its decision did not conflict with the result it reached previously in *Wilder* and validated that case as good law surviving the *Gonzaga* decision.

The Fifth Circuit's decision in *Hawkins* clearly is at odds with *Wilder* in its refusal to recognize a private right of action under § 1983 for enforcement of the Equal Access Provision. An analysis of this provision under *Gonzaga* does not foreclose a finding of an enforceable private right of action under § 1396a(a)(30)(A). Indeed, applying the "rights-creating language" test of *Gonzaga*, as outlined above, confirms that the Equal Access Provision does, in fact, provide for a private right of action for recipients of services under the Medicaid Act. Because *Hawkins* decides otherwise, this case presents an important question of federal law that must be settled by this Court.

CONCLUSION

For the reasons and based upon the authorities set forth in the Petition, Petitioners respectfully request that the Petition for Writ of Certiorari be granted.

Respectfully submitted,

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APPENDIX

APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT FILED DECEMBER 10, 2007

UNITED STATES COURT OF APPEALS FIFTH CIRCUIT

No. 06-50599.

Dec. 10, 2007.

EQUAL ACCESS FOR EL PASO, INC.; Monica Rivero, as next friend of Kevin Rivero; Patricia Duarte Melendez, in her individual capacity and as next friend of Orandie Jahssar Melendez-Duarte; Jessilyn Nagel, as next friend of Heidi Armstrong and McKenna Armstrong; Ruth Gallegos, in her individual capacity and as next friend of Amber Villegas,

Plaintiffs-Appellees,

v.

Albert HAWKINS, Commissioner of the Texas Health and Human Services Commission, individually and in his official capacity,

Defendant-Appellant.

Appeal from the United States District Court for the Western District of Texas.

Appendix A

Before DENNIS, CLEMENT and PRADO, Circuit Judges.

DENNIS, Circuit Judge:

This case requires us to determine whether, in light of the Supreme Court's decision in *Gonzaga University v. Doe*, 536 U.S. 273, 122 S.Ct. 2268, 153 L.Ed.2d 309 (2002), Medicaid recipients in El Paso County, Texas, may bring an action under 42 U.S.C. § 1983[1] to challenge whether the methods and procedures of the Texas State Medicaid Plan ("Plan") assure that the payments for care and services available under the Plan are sufficient to provide them with access to medical assistance "at least to the extent that such care and services are available to the general population in the geographic area" as required by 42 U.S.C. § 1396a(a)(30)(A). More specifically, the question presented is whether the so-called "Equal Access" requirement of § 1396a(a)(30)(A)

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1. Section 1983 provides in relevant part:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress . . . .

42 U.S.C. § 1983.

is enforceable in an action pursuant to § 1983 so as to afford declaratory and injunctive relief because the Medicaid payment rates for the El Paso area are deficiently priced to enlist enough providers to make medical assistance under the Plan available to the Medicaid recipients in the El Paso area at least to the extent that such care and services are available to the general (non-Medicaid) population in that area.

I. FACTUAL AND PROCEDURAL BACKGROUND

A.

Medicaid is a cooperative federal-state program through which the federal government provides financial assistance to states so that they may furnish medical care to needy individuals. *See* 42 U.S.C. § 1396 *et seq.* Although participation in the program is voluntary, participating states must comply with certain requirements imposed by the Medicaid Act, *id.*, and regulations promulgated by the Secretary of Health and Human Services ("Secretary"). To qualify for federal assistance, a state must submit to the Secretary and have approved a "plan for medical assistance," § 1396a(a), that contains a comprehensive statement describing the nature and scope of the state's Medicaid program. 42 C.F.R. § 430.10 (2007). The state plan is required to provide, among other things, methods and procedures for the payment of care and services under the plan necessary to assure their availability to the Medicaid population to the same extent as they are available to the general population in that geographic area. 42 U.S.C. § 1396a(a)(30)(A).

Appendix A

Section 1396a(a)(30)(A)of the Medicaid Act sets out the requirement that Medicaid recipients must be assured of "equal access" to medical assistance with the general populace in respect to plan-specified care and services, in pertinent part, as follows:

> A State plan for medical assistance must ... provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan ... as may be necessary ... to assure that payments ... are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area ....

42 U.S.C. § 1396a(a)(30)(A).

The state of Texas has elected to participate in the Medicaid program and has designated the Health and Human Services Commission ("HHSC"), of which defendant Hawkins is the commissioner, to administer its Plan. The Texas Medicaid program is financed through a joint federal-state arrangement, in which every $1 of state funds disbursed for Medicaid is matched by approximately $2 of federal funds. The HHSC compensates Medicaid providers through two programs: (1) the traditional fee-for-service program; and (2) the managed care program. Under the fee-for-service program, health care professionals are reimbursed based on fee schedules established by HHSC. These fee

schedules, which assign discrete codes, and in turn monetary values, to hundreds of different medical procedures, are in effect and consistent statewide. Under the managed care program, HHSC administers payments to participating managed care providers, such as health maintenance organizations, using capitation or per-head rates, which are fixed amounts paid to the participating providers on a per-member, per-month basis. The capitation rates vary according to market medical service prices in each geographic area.

B.

Plaintiff Equal Access for El Paso is a nonprofit corporation located in El Paso County, Texas, composed of individuals interested in the provision of health care in the El Paso geographic area. Its purpose is to develop health care resources and access to health care in that area. On October 24, 2003, Equal Access for El Paso, on behalf of its members, many of whom it alleges are Medicaid recipients and health care professionals and other providers directly and adversely impacted by HHSC's actions, and on behalf of the patients of its member health care professionals and providers, brought suit in the United States District Court for the Western District of Texas against HHSC.[2] Also joining in this suit were several individual Medicaid recipients residing in El Paso, who sued as individuals on their own behalf and on behalf of their respective children, as well

2. Plaintiffs amended their complaint on June 24, 2004, but the named parties remain the same.

as three health care providers (a doctor, a hospital, and a health maintenance organization) suing on their own behalf and on behalf of their Medicaid recipient patients/enrollees.[3] Together, these plaintiffs allege that HHSC set deficient Medicaid reimbursement and capitation rates, resulting in inadequate access to medical services for Medicaid recipients who live in the El Paso area as compared to the rest of the State and as compared to individuals covered by private insurance in the El Paso area. This follows, plaintiffs contend, because the inadequate reimbursement and capitation rates, when combined with the relatively high percentage of Medicaid recipients in the El Paso area, has created a financial incentive for physicians to relocate and practice in other communities in the State and for physicians practicing in the El Paso area to seek out patients covered by employer-sponsored insurance.

In the district court, plaintiffs originally brought suit under § 1983, alleging violations of six provisions of the Medicaid Act, the Supremacy Clause, and the Equal Protection Clause of the Fourteenth Amendment. HHSC then filed a motion to dismiss pursuant to Federal Rule of Civil Procedure 12(b)(1) for lack of subject matter jurisdiction and, in the alternative, Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim. The district court denied HHSC's 12(b)(1) motion,

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3. The district court dismissed the claims of both the individual providers and the provider members of Equal Access for El Paso, finding that the providers did not have a private right of action under 42 U.S.C. § 1396a(a)(30)(A). The dismissal of those claims is not before this court on interlocutory appeal.

finding that the plaintiffs had standing, but granted its 12(b)(6) motion, dismissing all of the plaintiffs' claims with the exception of the recipients' claim under § 1396a(a)(30)(A)'s "Equal Access" provision. The district court denied the defendant's motion with respect to the Equal Access claim because the court determined that this particular statutory provision confers on Medicaid recipients an individual federal right enforceable through § 1983.[4] On interlocutory appeal, HHSC contends that, in light of the Supreme Court's decision in *Gonzaga*, the Equal Access provision does not create a federal right of action enforceable through § 1983.[5]

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4. The district court was obliged to so decide by our prior decision in *Evergreen Presbyterian Ministries Inc. v. Hood*, 235 F.3d 908 (5th Cir.2000), in which we held that the Equal Access provision of § 1396a(30)(A) gave Medicaid recipients, but not providers, a federal statutory right enforceable under § 1983. In view of the fact that the Supreme Court's intervening decision in *Gonzaga*, 536 U.S. at 273, 122 S.Ct. 2268, may have partially overruled *Evergreen*, however, the district court elected to certify that question to us rather than to proceed immediately to determine whether declaratory and injunctive relief was appropriate.

5. HHSC also challenges on appeal the district court's determination that the Medicaid-recipient plaintiffs in this action have standing to assert a claim under the Equal Access provision. We agree with the district court's extensive analysis that plaintiffs' asserted injury—insufficient access to medical care and services—is fairly traceable to HHSC's conduct and will likely be redressed if they are granted the declaratory and injunctive relief that they have requested. Several courts have recognized the direct connection between Medicaid recipients'

(Cont'd)

II. STANDARD OF REVIEW

This court reviews *de novo* the district court's disposition of a motion to dismiss under either Rule 12(b)(1) or Rule 12(b)(6). *See Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough*, 354 F.3d 348, 351 (5th Cir.2003).

III. DISCUSSION

" 'Section 1983 imposes liability on anyone who, under color of state law, deprives a person "of any rights, privileges, or immunities secured by the Constitution

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access to medical care and services and low reimbursement rates. *See, e.g., Okla. Chapter of the Am. Acad. of Pediatrics v. Fogarty*, 366 F.Supp.2d 1050, 1106-07 (N.D.Okla.2005); *Memisovski ex rel. Memisovski v. Maram*, No. 92-C-1982, 2004 WL 1878332, at *42 (N.D.Ill. Aug.23, 2004) (unreported); *Clayworth v. Bonta*, 295 F.Supp.2d 1110, 1116 (E.D.Cal.2003), *rev'd on other grounds*, 140 Fed.Appx. 677 (9th Cir.2005); *Clark v. Kizer*, 758 F.Supp. 572, 577 (E.D.Cal.1990), *aff'd in relevant part, Clark v. Coye*, 967 F.2d 585 (9th Cir.1992); *Thomas v. Johnston*, 557 F.Supp. 879, 903-04 (W.D.Tex.1983). Moreover, we take judicial notice of the fact that HHSC has itself expressly recognized this connection in its bi-annual Consolidated Budget that it submitted to the Texas Legislature in October 2006, wherein it argued that "[r]ate increases for physicians would promote access to care for Medicaid clients that would likely erode without the increase." Tex. Health & Human Servs. Comm'n, Consol. Budget Financial Year R 2008-2009, at 54 (2006). We therefore have no difficulty concluding that the recipient plaintiffs have standing to assert their Equal Access provision claim.

and laws." ' " *Blessing v. Freestone*, 520 U.S. 329, 340, 117 S.Ct. 1353, 137 L.Ed.2d 569 (1997) (internal quotations omitted). The § 1983 remedy encompasses violations of rights secured by federal statutory as well as constitutional law. *Maine v. Thiboutot*, 448 U.S. 1, 4, 100 S.Ct. 2502, 65 L.Ed.2d 555 (1980). In order to seek redress through § 1983, therefore, "a plaintiff must assert the violation of a federal *right*, not merely a violation of federal *law*." *Blessing*, 520 U.S. at 340, 117 S.Ct. 1353 (emphasis in original) (citing *Golden State Transit Corp. v. Los Angeles*, 493 U.S. 103, 106, 110 S.Ct. 444, 107 L.Ed.2d 420 (1989)).

In *Gonzaga*, the Supreme Court noted that some language in its prior opinions had suggested that something less than an unambiguously conferred right is enforceable by § 1983. 536 U.S. at 282, 122 S.Ct. 2268. As an example, the Court quoted from *Blessing*: " 'Congress must have intended that the provision in question benefit the plaintiff,' 'the plaintiff must demonstrate that the right assertedly protected by the statute is not so "vague and amorphous" that its enforcement would strain judicial competence,' and 'the provision giving rise to the asserted right must be couched in mandatory, rather than precatory, terms.' " *Id.* (quoting *Blessing*, 520 U.S. at 340-41, 117 S.Ct. 1353). On the other hand, the Court pointed out that *Blessing*, in the same paragraph, emphasized that "it is only violations of rights, not laws, which give rise to § 1983 actions." *Id.* at 283, 122 S.Ct. 2268 (citing *Blessing*, 520 U.S. at 340, 117 S.Ct. 1353). Consequently, the Court in *Gonzaga* concluded that "[t]his confusion has led some

courts to interpret *Blessing* as allowing plaintiffs to enforce a statute under § 1983 so long as the plaintiff falls within the general zone of interest that the statute is intended to protect . . . ." *Id.*

After reviewing its previous decisions in some detail, the Supreme Court in *Gonzaga* expressly rejected "the notion that our cases permit anything short of an unambiguously conferred right to support a cause of action brought under § 1983." *Id.* The Court then declared:

> Section 1983 provides a remedy only for the deprivation of "rights, privileges, or immunities secured by the Constitution and laws" of the United States. Accordingly, it is *rights*, not the broader or vaguer "benefits" or "interests," that may be enforced under the authority of that section.

Id. (emphasis in original).

Further, the Court in *Gonzaga* set forth some of the factors from its prior cases that are indications of Congressional intent to make statutory provisions enforceable under § 1983. "[A] claim based on a statutory violation is enforceable under § 1983 only when the statute creates 'rights, privileges, or immunities' in the particular plaintiff." *Id.* at 285, 122 S.Ct. 2268 (quoting *Golden State Transit Corp.*, 493 U.S. at 108 n. 4, 110 S.Ct. 444). Such inquiries simply require a determination as to whether Congress intended to confer individual

rights upon a class of beneficiaries. *Id.* (citing *Alexander v. Sandoval*, 532 U.S. 275, 289, 121 S.Ct. 1511, 149 L.Ed.2d 517 (2001); *Wright v. Roanoke Redevelopment and Hous. Auth.*, 479 U.S. 418, 423, 107 S.Ct. 766, 93 L.Ed.2d 781 (1987); *California v. Sierra Club*, 451 U.S. 287, 294, 101 S.Ct. 1775, 68 L.Ed.2d 101 (1981)).

On the contrary, the *Gonzaga* Court observed, a statutory provision fails to confer enforceable rights when it "entirely lack[s] the sort of 'rights-creating' language critical to showing the requisite Congressional intent to create new rights," *id.* at 287, 122 S.Ct. 2268 (citing *Alexander*, 532 U.S. at 288-289, 121 S.Ct. 1511; *Cannon v. Univ. of Chi.*, 441 U.S. 677, 690 n. 13, 99 S.Ct. 1946, 60 L.Ed.2d 560 (1979)); when it "speak [s] only in terms of institutional policy and practice, not individual" concerns, *id.* at 288, 122 S.Ct. 2268; and when it has "an 'aggregate' focus [and is] not concerned with 'whether the needs of any particular person have been satisfied,' " *id.* (citing *Blessing*, 520 U.S. at 343-44, 117 S.Ct. 1353).

In *Gonzaga*, the Court explained that plaintiffs under § 1983 do not have the burden of showing an intent to create a private remedy because § 1983 generally supplies a remedy for the vindication of rights secured by federal statutes. Thus, once a plaintiff demonstrates that a statute confers an individual right, the right is presumptively enforceable by § 1983.[6] *Id.* at 284, 122 S.Ct. 2268.

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6. The Court in *Gonzaga* further explained that "[t]he State may rebut this presumption by showing that Congress (Cont'd)

Similarly, in the present case, the question of whether the State of Texas may rebut such a presumption does not arise due to our conclusion that the Equal Access provision confers no individual right within the context of this case enforceable under § 1983.

Applying the foregoing principles, we conclude that the Medicaid Act's Equal Access provision, 42 U.S.C. § 1396a(a)(30)(A), does not confer individual private rights that are enforceable under § 1983. The provision does not contain sufficient "rights-creating" language critical to showing unambiguously the requisite Congressional intent to create individualized rights for Medicaid recipients and health care providers. Even when read in the context of the entire statute, the Equal Access provision does not create rights for individuals

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(Cont'd)

'specifically foreclosed a remedy under § 1983.' " *Gonzaga Univ. v. Doe*, 536 U.S. 273, 285 n. 4, 122 S.Ct. 2268, 153 L.Ed.2d 309 (2002) (quoting *Smith v. Robinson*, 468 U.S. 992, 1004-05, n. 9, 104 S.Ct. 3457, 82 L.Ed.2d 746 (1984)). "The State's burden is to demonstrate that Congress shut the door to private enforcement either expressly, through 'specific evidence from the statute itself,' [*Wright*, 479 U.S. at 423, 107 S.Ct. 766], or 'impliedly, by creating a comprehensive enforcement scheme that is incompatible with individual enforcement under § 1983,' [*Blessing*, 520 U.S. at 341, 117 S.Ct. 1353]. *See also Middlesex County Sewerage Auth. v. National Sea Clammers Ass'n*, 453 U.S. 1, 20, 101 S.Ct. 2615, 69 L.Ed.2d 435 (1981)." *Id.* But the Court added that these questions did not arise in *Gonzaga* due to its conclusion that the Family Educational Rights and Privacy Act "confers no individual rights and thus cannot give rise to a presumption of enforceability under § 1983." *Id.*

or an identifiable class. It speaks only to the state and the Secretary in their functions of proposing and approving a state plan calculated to "enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." § 1396a(a)(30)(A). Thus, like the provisions at issue in *Gonzaga* and *Blessing,* the Equal Access provision speaks only in terms of institutional policy and practice, has an "aggregate" rather than an individualized focus, and is not concerned with whether the needs of any particular person or class of individuals have been satisfied. It therefore does not create a private individual right enforceable under § 1983.

Before *Gonzaga,* we held in *Evergreen,* 235 F.3d 908, 927-29 (5th Cir.2000), that Medicaid recipients, but not providers, may bring actions under § 1983 to enforce the Equal Access provision against a state administrator of a Medicaid state plan. It is evident, however, that the Supreme Court in *Gonzaga* abrogated *Evergreen* in respect to such suits by recipients while confirming it insofar as it disallows § 1983 actions by providers under the Equal Access provision.

We may no longer, as we did in *Evergreen,* resolve the ambiguities in *Blessing, Wilder,* and the Equal Access provision in favor of finding a Congressional intent to authorize Medicaid recipients to bring Equal Access provision suits under § 1983. We are forced by *Gonzaga* to abjure the notion that anything short of an unambiguously conferred private individual "right,"

rather than the broader or vaguer "benefits" or "interests," may be enforced under § 1983. Accordingly, we may not follow *Evergreen*'s essential inference that, because Congress's aim in the Medicaid Act was to protect the interests of health care recipients as its primary, ultimate beneficiaries, Congress necessarily meant for recipients to enforce the Equal Access provision in private suits under § 1983. The Equal Access provision has a clearly aggregate and systemic focus that deals with institutional policy and procedures, rather than an individualized focus concerned with whether the needs of any particular person or class of recipients have been satisfied. Consequently, we conclude that the Equal Access provision, which plausibly invests the Secretary with the exclusive power and duty of carrying it into effect, does not necessarily or unambiguously create, in addition, private rights in recipients to enforce Equal Access by individual or class suits under § 1983. *Accord Mandy R. v. Owens*, 464 F.3d 1139, 1148 (10th Cir.2006); *Westside Mothers v. Olszewski*, 454 F.3d 532, 542-43 (6th Cir.2006); *Sanchez v. Johnson*, 416 F.3d 1051, 1059-61 (9th Cir.2005) ; *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 57 (1st Cir.2004). *Contra Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 443 F.3d 1005, 1014-16 (8th Cir.2006), *vacated on other grounds, Selig v. Pediatric Specialty Care, Inc.*, __ U.S. __ __, 127 S.Ct. 3000, 168 L.Ed.2d 724 (2007).

IV. CONCLUSION

For these reasons, the district court's judgment partially denying the defendant's motion to dismiss the plaintiffs' Equal Access provision claim under § 1983 is REVERSED and the case is REMANDED to the district court with directions to enter a judgment dismissing all claims with prejudice.

APPENDIX B — ORDER GRANTING IN PART AND DENYING IN PART DEFENDANT'S AMENDED MOTION TO DISMISS AND CERTIFICATION FOR INTERLOCUTORY APPEAL OF THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF TEXAS, EL PASO DIVISION FILED MARCH 30, 2006

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
EL PASO DIVISION

No. EP-03-CA-440-PRM

EQUAL ACCESS FOR EL PASO, INC. et al.,

Plaintiffs,

v.

ALBERT HAWKINS, Commissioner of the Texas Health and Human Services Commission,

Defendant.

ORDER GRANTING IN PART AND DENYING IN PART DEFENDANT'S AMENDED MOTION TO DISMISS AND CERTIFICATION FOR INTERLOCUTORY APPEAL

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ORDER GRANTING IN PART AND DENYING IN PART DEFENDANT'S AMENDED MOTION TO DISMISS AND CERTIFICATION FOR INTERLOCUTORY APPEAL

On this day, the Court considered the following: (1) Defendant Albert Hawkins' ("Defendant") "Amended Motion to Dismiss," filed on May 18, 2005; (2) Plaintiffs Equal Access for El Paso, Inc.; El Paso County Hospital District d/b/a R.E. Thomason General Hospital; El Paso First Health Plans, Inc.; Dr. Jose Luna, Jr.; Monica Rivero, individually and as next friend of Kevin Rivero; Patricia Duarte Melendez, individually and as next friend of Orandie Jahssar Melendez-Duarte and Osnar Joshua Melendez; Jessilyn Nagel, as next friend of Heidi and McKenna Armstrong; and Ruth Gallegos's, individually and as next friend of Amber Villegas, (collectively "Plaintiffs") "Joint Response to Defendant Albert Hawkins's Amended Motion to Dismiss" ("Amended Motion to Dismiss"), filed on June 14, 2005; and (3) Defendant's "Reply on Amended Motion to Dismiss," filed on July 6, 2005 in the above-captioned cause. The Court also considered the oral arguments of counsel submitted at a status conference held on February 14, 2005.

After due consideration, the Court is of the opinion that Defendant's Amended Motion to Dismiss should be granted in part and denied in part for the reasons set forth below. The Court is also of the opinion that the above-captioned cause should be certified for interlocutory appeal to the Court of Appeals for the Fifth Circuit.

I. FACTUAL AND PROCEDURAL BACKGROUND

This case concerns alleged violations of the Medicaid Act, 42 U.S.C. § 1396, *et seq.* Specifically, Plaintiffs-comprised of (1) Medicaid recipients in El Paso County, Texas ("El Paso"); (2) Medicaid providers in El Paso; and (3) an association purporting to represent the interests of Medicaid recipients and providers in El Paso-are alleging that low Medicaid payment rates have impeded the access of El Paso Medicaid recipients to the medical services guaranteed by the Medicaid Act.

A. The Medicaid Act

"In the Social Security Amendments of 1965, Congress established Title XIX, commonly referred to as the 'Medicaid Act.' " *Evergreen Presbyterian Ministries Inc. v. Hood,* 235 F.3d 908, 914 (5th Cir.2000) (citing Pub.L. No. 89-97, 79 Stat. 286 (1965)). The Medicaid Act established a medical assistance program ("Medicaid") cooperatively funded by federal and state governments, which is designed to ensure the provision of medical services to disabled individuals and families with dependent children. Pls.' First Am. Compl., at 7, ¶ 19.

Appendix B

A state's participation in Medicaid is voluntary, but a participating state must adhere to the requirements of the Medicaid Act in order to receive federal funding. *Evergreen*, 235 F.3d at 915. One such requirement is that a state must submit a state plan to the Health Care Financing Administration for approval. *Id.* "A state plan is a 'comprehensive written statement' submitted by the state describing the nature and scope of the state's Medicaid program." *Id.* (citing 42 C.F.R. § 430.10). "The Medicaid Act sets out a laundry list of . . . items that must be contained within a valid state plan." *Id.* at 915 (citing 42 U.S.C. § 1396a(a) (2000)). Plaintiffs' claims include alleged violations of six of these requirements for a state Medicaid plan contained within the Medicaid Act. Texas has chosen to participate in Medicaid and has designated the Texas Health and Human Services Commission ("HHSC"), over whom Defendant Albert Hawkins is the commissioner, to administer the state's Medicaid plan. *Id.*

B. The Administration of Medicaid in Texas

HHSC pays Medicaid providers through two programs: (1) a traditional "fee-for-service" program; and (2) payments to managed care providers based on capitation rates. Pls.' First Am. Compl., at 3, ¶¶ 3-4. Under the fee-for-service program, health care professionals are reimbursed based on fee schedules established by HHSC, schedules that break down medical procedures into discreet codes, which in turn are each assigned a monetary value. *Id.* at 3, ¶ 3. In addition to the fee-for-service program, HHSC

administers payments to certain managed care providers, such as health maintenance organizations ("HMOs"), through capitation rates,[1] which are fixed amounts paid to participating providers on a per-member, per-month basis. Border Rate Report, at 3-4.

C. The Parties

Plaintiffs, who are suing Defendant in his official capacity as Commissioner of HHSC, are comprised of three distinct classes. The first class consists of a collection of Medicaid recipients residing in El Paso, Texas (collectively "Recipient Plaintiffs"). Recipient Plaintiffs are suing as individuals on their own behalf and on behalf of their respective children.

The second class consists of a doctor providing services to Medicaid recipients, an HMO, and a county

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1. Speaking generally, "[i]n United States health services, capitation refers to a fixed 'per capita' amount that is paid to a hospital, clinic, or doctor for each person served." *Camacho v. Tex. Workforce Comm'n*, 326 F.Supp.2d 803, 805 (W.D.Tex.2004). Apparently, HHSC develops future capitation payment rates using data from past fee-for-service claims for Medicaid services delivered in a geographic area before managed care is implemented. Pls.' App. to Their Resp. to Def's. Am. Mot. Dismiss, Ex. 1, Border Rate Workgroup on Medicaid and CHIP Final Report (hereinafter "Border Rate Report"), at 3. HHSC takes the fee-for-service data, based on cost and utilization of services, and projects the data for future years using trend factors. *Id.* at 4. HHSC then converts the average fee-for-service amount into a per-member, per-month figure and discounts that amount to obtain the capitation payment amount. *Id.*

hospital district (collectively "Provider Plaintiffs"). Provider Plaintiff Jose Luna, Jr., M.D. is suing on his own behalf and on behalf of his Medicaid recipient patients. Provider Plaintiff El Paso First Health Plans, Inc. ("El Paso First") is an HMO that is suing on its own behalf and on behalf of its Medicaid recipient enrollees. Provider Plaintiff El Paso Hospital District d/b/a R.E. Thomason General Hospital ("Thomason") owns and operates R.E. Thomason Hospital, an urban hospital, El Paso First Plans, Inc., and Thomason Cares Inc., a health organization that provides physician services. Thomason also employs health care professionals. Thomason is suing on its own behalf and on behalf of its Medicaid recipient patients.

The third class consists solely of Equal Access for El Paso, Inc. ("Equal Access"), a non-profit corporation "composed of individuals interested in the provision of health care in El Paso." Pls.' First Am. Compl., at 5, ¶ 10. Equal Access is suing on behalf of its members, many of whom it alleges are "Medicaid recipients and other health care professionals and other providers who are directly and adversely impacted by HHSC's actions." *Id.*

D. Plaintiffs' Claims

Plaintiffs filed suit against Defendant in federal court on October 23, 2003 and subsequently amended their complaint on June 24, 2004. Generally, Plaintiffs allege that HHSC's setting of deficient Medicaid

reimbursement and capitation rates[2] has prevented Medicaid recipients in El Paso from obtaining adequate access to medical services, in violation of certain provisions of the Medicaid Act, the Supremacy Clause, and the Equal Protection Clause. The alleged lack of access to adequate medical services is a result of the fact that inadequate Medicaid payment rates, when combined with El Paso's unique payor mix,[3] have created an incentive (1) for physicians to practice in communities other than El Paso and (2) for physicians practicing in El Paso County to seek out patients covered by employer-sponsored insurance. Pls.' First Am. Compl., at 14, ¶ 42.

Specifically, Plaintiffs' amended complaint sets forth eight claims, alleging six violations of the federal Medicaid Act under 42 U.S.C. § 1983 ("§ 1983"), violations of the Supremacy Clause, and a Fourteenth Amendment Equal Protection violation. Plaintiffs' first count alleges that HHSC's Medicaid payment rates for the El Paso area: (1) are deficiently priced to enlist enough providers so that care and services are available to the Medicaid recipients residing in the El Paso area to the extent care and services are available to the general (non-Medicaid) population in the El Paso area; and (2) are "not consistent with efficiency, economy, and quality of care," in violation

2. *See supra* note 1 (explaining capitation rates).

3. "Payor mix" refers to the percentage of people in a given geographic area that (1) are covered by Medicaid; (2) are covered by employer-sponsored medical insurance; and (3) are uninsured, respectively. Pls.' First Am. Compl., at 20, ¶ 40.

of 42 U.S.C. § 1396a(a)(30)(A) and 42 C.F.R. § 447.204. Pls.' First Am. Compl., at 21, ¶ 44. Plaintiffs' second count alleges that medical assistance available to El Paso Medicaid recipients is less in "amount, duration, and scope" than assistance made available to Medicaid recipients and "other individuals in other geographic areas," resulting in the denial of equal treatment and comparable care, contrary to 42 U.S.C. § 1396a(a)(10)(B) and 42 C.F.R. §§ 440.230 and 440.240. *Id.* at 22, ¶ 48. Plaintiffs' third count alleges that HHSC's Medicaid plan's distribution of federal and state funds, in conjunction with the "lack of adequate funds from local sources in the El Paso region," has resulted in the "lowering of the amount, duration, scope and quality of care and service" made available to Plaintiffs, in violation of 42 U.S.C. § 1396a(a)(2). *Id.* at 22-23, ¶ 51. Plaintiffs' fourth count alleges that HHSC failed to operate and administer the state Medicaid plan under equitable standards that are mandatory throughout the state, in violation of 42 U.S.C. § 1396a(a)(1) and 42 C.F.R. § 431.50(b)(1). *Id.* at 23, ¶ 54. In connection therewith, Plaintiffs also argue that it is inequitable for Texas to benefit from the poverty level in El Paso through increased federal funding while HHSC fails to ensure that El Paso receives proper and timely services through appropriate funding. *Id.* at 22-23, ¶ 54. Plaintiffs' fifth count alleges that medical assistance made available to Plaintiffs and other El Paso Medicaid recipients is not furnished with reasonable promptness to all eligible individuals, in violation of 42 U.S.C. § 1396a(a)(8) and 42 C.F.R. § 435.930. *Id.* at 24, ¶ 57. Plaintiffs' sixth count alleges that HHSC has failed to establish capitation rates

on an actuarially sound basis and concludes that HHSC's contracts with managed care organizations therefore violate 42 U.S.C. § 1396b(m)(2)(A)(iii). Pls.' First Am. Compl., at 25, ¶ 60. Plaintiffs' seventh count alleges that House Bill 1 ("HB1") of the 78th Texas Legislature and HHSC's practices in administering Medicaid in El Paso County violate the Supremacy Clause of the U.S. Constitution due to inconsistencies with 42 U.S.C. §§ 1396a(a)(30)(A), (a)(10)(B), (a)(2), (a)(1), (a)(8), and 1396b(m)(2)(A)(iii). *Id.* at 25, ¶ 23. Finally, Plaintiffs' eighth count alleges that HHSC does not treat El Paso Medicaid enrollees equally when compared with other individuals in Texas, in that Medicaid recipients in El Paso receive much less funding per person than the average Medicaid recipient in Texas, in violation of the Equal Protection Clause of the Fourteenth Amendment. *Id.* at 26, ¶ 66. As a result of the aforementioned alleged violations, Plaintiffs seek injunctive and declaratory relief pursuant to § 1983, Title 28 of United States Code § 2201, and Federal Rule of Civil Procedure 57.

On May 18, 2005, Defendant filed an Amended Motion to Dismiss contending that all Plaintiffs lack standing to maintain any of the above-listed causes of action, mandating a dismissal pursuant to Federal Rule of Civil Procedure 12(b)(1) ("Rule 12(b)(1)") for lack of subject-matter jurisdiction. Alternatively, Defendant argues that Plaintiffs fail to state a claim under any of the above-listed causes of action, requiring dismissal pursuant to Federal Rule of Civil Procedure 12(b)(6) ("Rule 12(b)(6)"). Defendant also asks the Court to find that the minor plaintiffs' ("Plaintiff-children") claims are

barred because of an ongoing class action. Finally, Defendant asks the Court, in the event of a denial of its motion to dismiss, to certify this case for interlocutory appeal to the Court of Appeals for the Fifth Circuit. The Court will address each of Defendant's arguments in turn.

II. DEFENDANT'S RULE 12(b)(1) MOTION

A. Article III Standing and Prudential Considerations[4]

The federal judicial power extends only to actual "cases" and "controversies." U.S. Const. art. III, § 2, cl. 1. Thus, it is well-settled that the Court may act only "in the context of a justiciable case or controversy." *Securities Exch. Comm'n v. Med. Comm. for Human Rights*, 404 U.S. 403, 407, 92 S.Ct. 577, 30 L.Ed.2d 560 (1972) (internal quotations and citation omitted). "The several doctrines that have grown up to elaborate that requirement are 'founded in concern about the proper-and properly limited-role of the courts in a democratic society.' " *Allen v. Wright*, 468 U.S. 737, 750, 104 S.Ct.

4. The Court will first evaluate whether any class of plaintiffs has standing to assert any of the causes of action at issue. *Ramming v. United States*, 281 F.3d 158, 161 (5th Cir.2001) ("When a Rule 12(b)(1) motion is filed in conjunction with other Rule 12 motions, the court should consider the Rule 12(b)(1) jurisdictional attack before addressing any attack on the merits."). If the Court finds that any plaintiffs have standing, it will proceed to evaluate Defendant's motion to dismiss pursuant to Rule 12(b)(6).

3315, 82 L.Ed.2d 556 (1984) (quoting *Warth v. Seldin*, 422 U.S. 490, 498, 95 S.Ct. 2197, 45 L.Ed.2d 343 (1975)). "[T]he core component of standing is an essential and unchanging part of the case-or-controversy requirement of Article III." *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560, 112 S.Ct. 2130, 119 L.Ed.2d 351 (1992). The term standing refers to "whether [a] particular plaintiff is entitled to an adjudication of the particular claims asserted." *Allen*, 468 U.S. at 752, 104 S.Ct. 3315. "[I]t is the burden of the party who seeks the exercise of jurisdiction in his favor . . . clearly to allege facts demonstrating that he is a proper party to invoke judicial resolution of the dispute." *United States v. Hays*, 515 U.S. 737, 743, 115 S.Ct. 2431, 132 L.Ed.2d 635 (1995) (internal quotations and citations omitted). Standing is composed of both constitutional Article III requirements and prudential considerations. *Elk Grove Unified Sch. Dist. v. Newdow*, 542 U.S. 1, 124 S.Ct. 2301, 2308, 159 L.Ed.2d 98 (2004).

1. Article III Requirements

"[T]he irreducible constitutional minimum of standing contains three elements." *Lujan*, 504 U.S. at 560, 112 S.Ct. 2130. First, a plaintiff must show he has suffered an injury-in-fact. *Id.* That is, a plaintiff must allege, and ultimately prove, that he has suffered a harm that is concrete and particularized and actual and imminent, not merely conjectural or hypothetical. *Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 103, 118 S.Ct. 1003, 140 L.Ed.2d 210 (1998); *Lujan*, 504 U.S. at 560, 112 S.Ct. 2130.

Second, the plaintiff must demonstrate a causal connection between the injury and the defendant's alleged conduct. *Lujan*, 504 U.S. at 560, 112 S.Ct. 2130. This means that the injury must be one that is fairly traceable to "the challenged action of the defendant, and not injury that results from the independent action of some third party not before the court." *Simon v. E. Ky. Welfare Rights Org.*, 426 U.S. 26, 41-42, 96 S.Ct. 1917, 48 L.Ed.2d 450 (1976). The "fairly traceable" standard does not require that a defendant's conduct be the sole cause of the plaintiff's injury. *See Etuk v. Slattery*, 936 F.2d 1433, 1441 (2nd Cir.1991) (finding the causation prong satisfied and noting that, "[w]hile perhaps not the sole cause, the alleged improper conduct of the [Defendant] plainly constituted a primary factor in the harm that plaintiffs contend they have suffered and will continue to suffer").

Third, "it must be likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision." *Lujan*, 504 U.S. at 561, 112 S.Ct. 2130 (internal quotations and citations omitted). "To survive a motion to dismiss, a plaintiff 'must allege facts from which it reasonably could be inferred that, absent the [defendant's conduct], there is a substantial probability that . . . if the court affords the relief requested, the asserted [injury] will be removed.' " *Nat'l Wrestling Coaches Ass'n v. Dep't of Educ.*, 366 F.3d 930, 944 (D.C.Cir.2004) (quoting *Warth*, 422 U.S. at 504, 95 S.Ct. 2197 (1975)). Plainly, the relief sought must redress

the injury suffered by the plaintiff.[5] *Steel Co.*, 523 U.S. at 107, 118 S.Ct. 1003 ("Relief that does not remedy the injury suffered cannot bootstrap a plaintiff into federal court; that is the very essence of the redressability requirement."). Reference to mere possibilities that a favorable decision from the court would provide redress for a plaintiff's injuries is insufficient to satisfy the redressability prong. *Nat'l Wrestling Coaches Ass'n*, 366 F.3d at 942 (noting that an associational plaintiff's reliance on the possibility that a favorable decision would confer "better odds" that its members' injuries would be redressed fell far short of the standard set by other cases where the redressability prong was satisfied).

2. Prudential Standing Requirements

"Beyond the constitutional requirements, the federal judiciary has also adhered to a set of prudential principles that bear on the question of standing." *McClure v. Ashcroft*, 335 F.3d 404, 411 (5th Cir.2003) (citation omitted). Prudential considerations encompass both third-party standing and standing for associations to sue on behalf of their members.

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5. The relief sought need not completely, or with certainty, redress the alleged injury, though it must, at least, significantly redress the injury. *Int'l Ladies Garment Workers Union v. Donovan*, 722 F.2d 795, 812 n. 27 (D.C.Cir.1983). Relief sufficiently redresses injury "if the relief [a plaintiff] seeks would redress the injury in whole or in part and thus confer a material benefit on [the plaintiff]." *Bruggeman v. Blagojevich*, 324 F.3d 906, 909 (7th Cir.2003).

Appendix B

a. Third-Party Standing

Ordinarily, a plaintiff must assert his own legal rights and cannot rest his claims on the rights of third-parties. *Powers v. Ohio,* 499 U.S. 400, 410, 111 S.Ct. 1364, 113 L.Ed.2d 411 (1991). However, some litigants may bring an action on behalf of third-parties if three criteria are satisfied. *Id.* First, "[t]he litigant must have suffered an 'injury in fact,' thus giving him or her a 'sufficiently concrete interest' in the outcome of the issue in dispute[.]" *Id.* (citation omitted). Second, the litigant must have a close relation to the third-party. *Id.* Third, "there must exist some hindrance to the third party's ability to protect his or her own interests." *Id.*

b. Associational Standing

Similarly, an association or organization has standing to bring suit on behalf of its members if three criteria are met. *Hunt v. Wash. State Apple Adver. Comm'n,* 432 U.S. 333, 343, 97 S.Ct. 2434, 53 L.Ed.2d 383 (1977). First, members of the organization must otherwise have standing to sue in their own right. *Id.* Second, the interests the organization seeks to protect must be germane to the organization's purpose. *Id.* Third, "neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit." *Id.* The first two requirements are Article III case or controversy requirements, while the third requirement is a prudential limitation that may be abrogated by congressional action. *United Food & Commercial Workers Union Local 751 v. Brown Group,*

Inc., 517 U.S. 544, 555-56, 558, 116 S.Ct. 1529, 134 L.Ed.2d 758 (1996).

As an overall principal, at the pleading stage, a plaintiff's complaint must "sufficiently [allege] a redressable injury-in-fact which is causally connected to the alleged conduct of [a defendant]. . . . '[G]eneral factual allegations of injury resulting from the defendant's conduct may suffice, for on a motion to dismiss we presume that general allegations embrace those specific facts that are necessary to support the claim.' " *Meadowbriar Home for Children v. Gunn*, 81 F.3d 521, 529 (5th Cir.1996) (quoting *Lujan*, 504 U.S. at 561, 112 S.Ct. 2130).

The Court will now proceed to determine each class of plaintiff's standing to sue in light of the applicable law, as well as the standing of all the plaintiffs to assert their Supremacy Clause claim.

B. Recipient Plaintiffs' Standing to Sue

1. Injury-in-fact

Defendant contends that Recipient Plaintiffs lack standing to bring any of the causes of action brought asserted to the Medicaid Act. Both parties concede that Recipient Plaintiffs have alleged an injury-in-fact in that Recipient Plaintiffs represent that they have experienced difficulties in accessing medical assistance in the El Paso area. This lack of access is manifested in difficulty encountered in obtaining appointments from

a medical provider that accepts Medicaid, excessively long waiting periods while in providers' offices, and a complete lack of certain medical services for Medicaid recipients in the El Paso area resulting in Recipient Plaintiffs' need to travel to other parts of the state to receive the services. Additionally, Plaintiffs allege an overall shortage of medical service professionals (whether or not they accept Medicaid patients) in the El Paso area, a problem which Plaintiffs indicate arguably implies that El Paso physicians have migrated to other areas of Texas. *See* Pls.' First Am. Compl., at 10, ¶ 25 (claiming that one Recipient Plaintiff's "problems stems from lack of physicians and therapists in the El Paso area"); *id.* at 10, ¶ 26 (alleging that one Recipient Plaintiff's "problems stem form the lack of physicians and dentists in the El Paso area").

At issue is whether, at this stage of the litigation, Recipient Plaintiffs have adequately pled the causation and redressability requirements necessary for standing to sue for their alleged injuries comprising difficulties in accessing medical services paid for by Medicaid funds.

2. Causation

Recipient Plaintiffs allege that their difficulties in obtaining adequate access to medical care is the result of "extremely low payment schedules under Medicaid." Pls.' First Am. Compl., at 10, ¶ 25. Hence, Recipient Plaintiffs attempt to attribute their injuries to HHSC, which sets the Medicaid reimbursement and capitation rates for the state of Texas.

Appendix B

A concept integral to Plaintiffs' causation theories is described by the term "payor mix." "Payor mix" refers to the percentage of residents in a particular geographic area that have employer-provided insurance, are covered by Medicaid, or are uninsured, respectively. Pls.' First Am. Compl., at 20, ¶ 40. According to Plaintiffs, other counties in Texas, though similar in size to El Paso, have payor mixes more favorable to medical providers. *Id.* That is, these counties have a higher percentage of residents with private insurance coverage, coverage which reimburses providers at higher rates than Medicaid.[6]

Plaintiffs allege that low payment rates have resulted in inadequate access to medical services[7] for

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6. As an example, Plaintiffs' complaint notes that, according to the 2000 census, 32 percent of El Paso County residents had employer-provided insurance, 16 percent were covered by Medicaid, and 35 percent were uninsured. Pls.' First Am. Compl., at 20, ¶ 40. In contrast, in Travis County, 69 percent of residents have private insurance, only 5 percent are covered by Medicaid, and 18 percent are uninsured. *Id.*

7. Although the Court finds a lack of access to medical care to be Recipient Plaintiffs' core injury, they also allege related injuries such as a failure to receive access to medical care equal to that of Medicaid recipients in other parts of the state. However, the Court finds that Recipient Plaintiffs only state a cognizable claim under the portion of the Medicaid Act which the Court refers to as the "Equal Access Provision," as discussed *infra* in Part III. Therefore, it is not necessary for the Court to discuss alleged injuries more directly tied to other provisions of the Medicaid Act.

Appendix B

El Paso Medicaid recipients through two distinct intermediate mechanisms: (1) creating an incentive for health care professionals in El Paso to curtail their participation in Medicaid or drop out completely; and (2) creating an incentive for health care professionals in El Paso to relocate to other parts of the state. Although Plaintiffs assert these causal mechanisms jointly, the Court will examine each mechanism separately for the sake of clarity.[8] However, if the Court determines that Plaintiffs' injuries are fairly traceable to HHSC's conduct through the first mechanism, the Court need only analyze the second mechanism to determine whether it renders Plaintiffs' overall causation theory too speculative. The Court will begin by analyzing the first causation mechanism, the curtailment and termination of the participation of El Paso medical professionals in Medicaid.

Defendant argues that Plaintiffs' claims are indistinguishable from the claims of the plaintiffs in *Allen v. Wright*, 468 U.S. 1250, 105 S.Ct. 51, 82 L.Ed.2d 942 (1984), and in *Simon v. E. Ky. Welfare Rights*, 426 U.S. 26, 96 S.Ct. 1917, 48 L.Ed.2d 450 (1976). In *Allen*, parents of black public school children brought a nationwide class action against the Internal Revenue Service ("IRS"), alleging that the IRS had "not adopted sufficient standards and procedures to fulfill its

8. The necessity for this approach becomes apparent when the Court explains the second mechanism's dependence on El Paso's payor mix, an independent factor that weakens the connection between low rates and Recipient Plaintiffs' alleged injuries.

obligation to deny tax-exempt status to racially discriminatory private schools." 468 U.S. at 739, 104 S.Ct. 3315. As a result of the IRS's actions, the parents alleged harm in the form of interference with their children's abilities to receive an education in desegregated public schools. *Id.* at 739-40, 104 S.Ct. 3315.[9] However, the Court held that the chain of causation between the IRS's alleged conduct and desegregation at the plaintiffs' schools was "attenuated at best." *Id.* at 757, 104 S.Ct. 3315. The Court held that it was speculative (1) "whether withdrawal of a tax exemption from any particular school would lead the school to change its policies;" and (2) "whether, in a particular community, a large enough number of the numerous relevant school officials and parents would reach decisions that collectively would have a significant impact on the racial composition of public schools." *Id.* at 758, 104 S.Ct. 3315.

In *Simon*, indigents and organizations composed of indigents brought suit against the Secretary of the Treasury and the Commissioner of the IRS, alleging that the IRS violated the Internal Revenue Code and the Administrative Procedure Act "by issuing a Revenue Ruling allowing favorable tax treatment to a nonprofit hospital that offered only emergency-room services to indigents." 426 U.S. at 29, 96 S.Ct. 1917. The *Simon* plaintiffs alleged that the IRS's Revenue Ruling "had

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9. The *Allen* plaintiffs actually alleged two forms of harm. *Allen*, 468 U.S. at 752, 104 S.Ct. 3315. However, the Court held that the first alleged harm, a stigma resulting from racial discrimination, did not constitute a judicially cognizable injury. *Id.* at 753, 104 S.Ct. 3315.

'encouraged' hospitals to deny services to indigents." *Id.* at 42, 96 S.Ct. 1917. However, the Court held that it was speculative "whether the denials of service specified in the complaint fairly can be traced to [the IRS's] 'encouragement' or instead result from decisions made by the hospitals without regard to the tax implications." *Id.* at 42-43, 96 S.Ct. 1917. As the *Allen* Court explained in its discussion of *Simon*, "the causal connection [in *Simon*] depended on the decisions hospitals would make in response to withdrawal of tax-exempt status, and those decisions were sufficiently uncertain to break the chain of causation between the plaintiffs' injury and the challenged Government action." *Allen*, 468 U.S. at 759, 104 S.Ct. 3315.

In the instant case, like in *Allen* and *Simon*, Plaintiffs' causation theory (focusing on their first causal mechanism) requires the Court to engage in speculation to some extent. In order to conclude that HHSC's setting of low payment rates results in a denial of access, the Court must assume that higher rates would have discouraged medical providers from curtailing or terminating their involvement in Medicaid. To make this assumption, like in *Allen* and *Simon*, the Court must speculate as to the actions of an independent third party. Like the schools in *Allen* and the hospitals in *Simon*, the Court must assume that medical providers, if given higher payment rates, would have chosen to maintain their current levels of involvement in Medicaid. This assumption is made more difficult in light of the fact that the Medicaid Act does not quantify the level at which a state must set payment rates in order to comply with its

requirements. In fact, as long as HHSC pays Medicaid providers one dollar less than private insurance pays, medical professionals would arguably have an incentive to prefer private insurance. Therefore, it is difficult to know whether the increased rates would have provided a sufficient incentive for medical providers to continue participation in Medicaid. Additionally, the Court must assume that a large enough percentage of providers would have decided to continue their participation in Medicaid to bring about a significant impact on the level of access to medical services for El Paso Medicaid recipients. *See Allen*, 468 U.S. at 758, 104 S.Ct. 3315 (requiring the plaintiffs to show that if the IRS had adequately enforced anti-discrimination policies it would have had a "*significant impact* on the racial composition of public schools") (emphasis added). Finally, like in *Simon*, the Court must speculate whether the decisions of Medical providers to decrease involvement in Medicaid was a result of low payments or of independent factors.[10]

Although the circumstances in *Allen* and *Simon* were arguably similar to the instant case, the Court finds that they are distinguishable, in part because of the characteristics of the Medicaid Act. Specifically, a portion of 42 U.S.C. § 1396a(a)(30)(A), which portion the Court

10. For example, Plaintiffs' complaint indicates one factor that contributed to the decisions of medical professionals to curtail involvement in Medicaid is El Paso's unique payor mix. *See infra* p. 19 (discussing the impact of El Paso's payor mix on Plaintiffs' causation theory).

will refer to as the "Equal Access Provision,"[11] actually requires the *result* that medical services must be available to Medicaid recipients in a geographic area "at least to the extent that such care and services . . . are available to the general population in a geographic area." *See Clark v. Richman*, 339 F.Supp.2d 631, 633 (stating that "the equal access provision is results-oriented").[12] Therefore, although a statute cannot relax the requirements of Article III standing, the terms of the statute informs the Court's counterfactual speculation. Literal compliance with the Equal Access Provision by its very terms requires a certain amount of access to medical services that Plaintiffs claim does not currently exist. Therefore, it is less tenuous for the Court to speculate that compliance with the statute would have resulted in better access to healthcare, when compared

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11. The Equal Access Provision is significant because it is the only provision of the Medicaid Act pursuant to which the Court finds that Plaintiffs have stated a cognizable claim, as discussed *infra* Part III.

12. 42 U.S.C. § 1396a(a)(30)(A) (" § 30(A)") states in relevant part as follows:

> A State plan for medical assistance must—
>
> (30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as . . . are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services care available to the general population in the geographic area[.]

with the degree of speculation required of the *Allen* and *Simon* Courts.

Furthermore, other courts have recognized the connection between access to medical services and low reimbursement rates, a connection made by the Equal Access Provision itself. *See Okla. Chapter of the Am. Acad. of Pediatrics v. Fogarty,* 366 F.Supp.2d 1050, 1106-07 (N.D.Okla.2005) ("While there is no established percentage for sufficient Medicaid reimbursement rates under federal law, rates which consistently fall well below what is allowed under Medicare, let alone under private insurance, have been shown to be inadequate to attract enough providers. . . ."); *Memisovski v. Maram,* No. 92 C 1982, 2004 WL 1878332, at *42 (N.D.Ill. Aug.23, 2004) (stating that "[r]ates and equal access [to medical services] simply cannot be divorced") (unpublished opinion);[13] *Clayworth v. Bonta,* 295 F.Supp.2d 1110, 1116 (E.D.Cal.2003) (finding that Medicaid recipient plaintiffs presented sufficient evidence that some Medicaid providers would cease participating in Medicaid or refuse to take new patients if rates were reduced), *rev'd on other grounds,* 140 Fed.Appx. 677 (9th Cir.2005); *Thomas v. Johnston,* 557 F.Supp. 879, 903-04 (W.D.Tex.1983) (reasoning that "[t]he link between the adequacy of reimbursement rates paid to providers and the adequacy of care provided to Medicaid recipients is quite obvious"). Invariably, the link between a lack of

13. Though *Memisovski* is an unpublished opinion, the Court finds that its reasoning and logic persuasively apply to the instant case. 5th Cir. R. 47.5.4 (stating "[a]n unpublished opinion may . . . be persuasive").

access and low reimbursement rates (to the extent a court explains the connection) is through the mechanism of low reimbursement rates creating an incentive for medical professionals to curtail or terminate their participation in Medicaid. *See, e.g., Fogarty,* 366 F.Supp.2d at 1063 (finding that Oklahoma pediatricians choose not to participate in Medicaid due to low reimbursement rates); *Clayworth,* 295 F.Supp.2d at 1116 (deciding that the plaintiffs had presented sufficient evidence that some California Medicaid providers would cease participating in the state's program or curtail their participation if the reimbursement rates were reduced by 5%).

Although several courts have found a sufficient connection between reimbursement rates and a lack of medical services, one unique feature of Plaintiffs' claims is that they attribute their injuries in part to El Paso's unique payor mix. In addition to *enabling* (as a necessary factor) the second mechanism, Plaintiffs allege that El Paso's payor mix *contributes* to the first mechanism's unique effect on the El Paso area because medical professionals who remain in El Paso have an increased financial incentive to terminate involvement in Medicaid, when compared with professionals in regions with more favorable payor mixes. Pls.' First Am. Compl., at 3, ¶ 3.[14] This incentive is a result of the fact that an El Paso

14. With respect to the second mechanism, the flight of El Paso medical professionals, the fact that the payor mix is a necessary condition makes the mechanism less likely to withstand Article III standing scrutiny than Plaintiffs' first causation mechanism, when viewing the mechanisms in isolation.

provider who accepts Medicaid patients is forced to accept the lower paying patients as a larger portion of the provider's business. Pls.' First. Am. Compl., at 3, ¶ 3. However, Plaintiffs do not allege that the payor mix is a result of HHSC's actions.

The fact that Plaintiffs' own complaint admits that the independent factor of El Paso's unique payor mix contributes to their lack of access militates against a finding that Recipient Plaintiffs' injuries are fairly traceable to low rates. However, at least one court has found that an allegation about the effects of the payor mix is not fatal to a plaintiff's allegation that low reimbursement rates caused a denial of access to medical care. *See Fogarty,* 366 F.Supp.2d at 1064-65 (finding that the "high percentage" of Medicaid recipients in rural Oklahoma counties contributed to the effects of low reimbursement rates on access to medical services in those counties). In addition, the "fairly traceable" standard does not require that a defendant's conduct be the sole cause of the plaintiff's injury. *See Etuk,* 936 F.2d at 1441 (finding it sufficient that the defendant's conduct was a "primary factor" in the plaintiff's injuries). Therefore, although it is a close question, the Court finds that Plaintiffs' allegation about the effects of the payor mix does not alter its conclusion that Recipient Plaintiffs' injuries are fairly traceable to HHSC's conduct through the first mechanism. For similar reasons, the Court finds that Plaintiff's second alleged mechanism, also dependent on El Paso's payor mix, does not render

Plaintiffs' causation theory too speculative.[15] Thus the Court finds that Plaintiffs' alleged lack of access to medical services is fairly traceable to HHSC's conduct.

3. Redressability

To redress the alleged violations of the Medicaid Act, Plaintiffs seek an injunction enjoining HHSC from failing to comply with the Medicaid Act, and specifically from failing to set payment rates in El Paso sufficiently "to enlist enough providers so that care and services are available to Plaintiffs at least to the extent that such care and services are available to the general population." Pls.' First Am. Compl., at 27.

In order to evaluate Plaintiffs' allegations of redressability, it is necessary to understand the relief mechanisms through which Plaintiffs claim their injury will be redressed by a favorable decision. Similarly to their causation theory, Plaintiffs' redressability theory again relies on two mechanisms: (1) if HHSC raises

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15. Another possible distinguishing feature of Plaintiffs' claims is that Plaintiffs allege both inadequate reimbursement rates (a somewhat common claim) and inadequate capitation rates (a unique claim). Plaintiffs appear to claim that low reimbursement rates *caused* their injuries and low capitation rates *perpetuate* their injuries. Pls.' First Am. Compl., at 21, ¶ 42. However, the fact that Plaintiffs allege both low reimbursement and low capitation rates does not alter the Court's standing analysis. Plaintiffs' allegation of inadequate reimbursement rates is sufficient in and of itself, and the additional allegation regarding inadequate capitation rates does not render Plaintiffs' overall theory too speculative.

Medicaid payment rates, medical professionals already in El Paso will decide to begin or increase their involvement in Medicaid; or (2) if HHSC raises payment rates, medical professionals will decide to return to El Paso.[16]

Again, the Court will begin by analyzing the merits of Plaintiffs' redressability argument by focusing on the first redressability mechanism in isolation. In order to conclude that Plaintiffs' requested relief would result in better access to medical services, Plaintiffs ask the Court to engage in speculation similar to that required of the Court in its causation analysis. Specifically, the Court must conclude that raising Medicaid payment rates would result in (1) medical professionals deciding to begin or increase their involvement in Medicaid and (2) enough professionals making this decision to significantly impact Recipient Plaintiffs' access to medical services.

However, once again the Court's speculation is aided by the requirements of the Equal Access Provision. Plaintiffs' requested relief, by definition, will result in

16. Plaintiffs now attempt to claim that it is only necessary to show that raising rates would eliminate the incentives for medical professionals to curtail involvement in Medicaid or migrate to other areas of Texas. However, it is necessary for Plaintiffs to show that the Court's action would redress *their injury*, namely, a lack of access to medical care. Plaintiffs cannot lower the constitutional requirements of redressability by couching their injury in terms of the incentives of medical professionals to take certain actions.

increased access to medical services. Although the Equal Access Provision cannot lower the constitutional requirements of redressability, it is by its nature results-oriented. *See Clark v. Richman*, 339 F.Supp.2d 631, 633 (stating that "the equal access provision is results-oriented").[17] Additionally, as discussed above, other courts have found similar claims to meet the requirements of redressability. *See supra* p. 18 (listing cases that have found claims alleging inadequate reimbursement rates sufficient to meet the requirements of Article III standing). Therefore, the Court finds that it is not too speculative to conclude that a favorable decision would redress Recipient Plaintiffs' injuries through the first redressability mechanism.

Additionally, the Court finds that Plaintiffs' second redressability mechanism does not render Plaintiffs'

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17. The fact that the Equal Access Provision is results-oriented should factor into a court's decision whether Congress intended it to create a private right of Action. A court should view a provision as precatory rather than mandatory if literal compliance with the statute is unrealistic. *See infra* Part III(A)(2) (describing the appropriate standard for determining whether a statute creates a federal right enforceable under § 1983). However, the Court ultimately concludes that it is bound by Fifth Circuit precedent to hold that the Equal Access Provision confers a private right of action upon Medicaid recipients. *See infra* Part III(B) (holding that the Equal Access Provision confers a private right of action upon Recipient Plaintiffs). Furthermore, the fact that the statute requires unrealistic results does not alter the Court's redressability analysis.

overall redressability theory too speculative.[18] Therefore, the Court finds that it is likely that Recipient Plaintiffs' injuries will be redressed by the requested relief. Thus, Recipient Plaintiffs meet all three requirements of Article III standing to allege that low Medicaid payment rates have resulted in their lack of access to medical services.

C. Provider Plaintiffs' Standing to Sue

Provider Plaintiffs assert claims both on their own behalf and on behalf of the Medicaid recipients they serve. The Court concludes that Provider Plaintiffs' have standing to sue on their own behalf, but not on behalf of their patients.

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18. Like Plaintiffs' causation theory, the second redressability mechanism's dependence on El Paso's payor mix renders Plaintiffs' overall redressability theory more speculative. However, for the same reasons mentioned when addressing Plaintiffs' second causation mechanism, the Court finds that Plaintiffs' second redressability mechanism does not render Plaintiffs' overall redressability theory too speculative. *See Fogarty*, 366 F.Supp.2d at 1064-65 (addressing the merits of the plaintiff's Equal Access claim despite allegations based in part on the "high percentage" of Medicaid recipients in rural Oklahoma counties); *Bruggeman*, 324 F.3d at 910 (stating that "[s]tanding is a matter of probabilities rather than certainties").

Appendix B

1. Provider Plaintiffs' Standing on Their Own Behalf[19]

Plaintiffs allege that Provider Plaintiffs have suffered the following injuries as a result of low Medicaid payment rates: (1) Provider Plaintiffs provide medical services for inadequate payment rates; (2) Provider Plaintiffs are "incapable of serving the existing Medicaid population in El Paso"; (3) Provider Plaintiffs' "Medicaid Recipient patients are deprived of their right to receive safe, timely, and adequate medical care"; (4) Plaintiff Thomason "is unable to provide [adequate] services to its Medicaid recipient patients"; and (5) Plaintiff El Paso First is unable "to develop the kind of provider base necessary to ensure that Medicaid recipients have access to Medicaid services equivalent to that of non-Medicaid recipients." Pls.' First Am. Compl., at 13-15.

Defendant argues that the first three injuries asserted by Provider Plaintiffs, as well as Plaintiff Thomason's alleged injury, involve the denial of access to medical services to Provider Plaintiffs' *patients* rather than to Provider Plaintiffs themselves. Similarly, Defendant argues that the injury asserted by El Paso First is an injury to its members. As a result, Defendant asserts that Provider Plaintiffs cannot meet the requirements of standing because they are asserting the injuries of their patients or members. *See Cent. & Sw.*

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19. The Court ultimately concludes that Provider Plaintiffs have not asserted any cognizable claims under the Medicaid Act. However, the Court will address Provider Plaintiffs' standing for the sake of thoroughness.

Srvs., Inc. v. U.S. Envtl. Prot. Agency., 220 F.3d 683, 699 (5th Cir.2000) (stating that "a party may not base its Article III standing on alleged injuries to others").

However, in addition to the allegations more directly implicating their patients' interests, Provider Plaintiffs also allege that HHSC's payment rates, which are paid to Provider Plaintiffs, are inadequate. Pls.' First Am. Compl., at 13, ¶ 30. This is an injury to Provider Plaintiffs themselves. *See Clayworth,* 295 F.Supp.2d at 1116 (stating that Medicaid providers would "suffer concrete injury" as a result of a reimbursement rate cut if allowed to go into effect); *see also Evergreen,* 235 F.3d at 928 (addressing whether Medicaid providers have a private right of action to challenge a reimbursement rate cut as a violation of § 30(A) without addressing the providers' standing). Therefore, the Court holds that Provider Plaintiffs' injuries are sufficiently particularized.

Additionally, Plaintiffs do not contest that Provider Plaintiffs meet the requirements of causation and redressability. Furthermore, the Court finds that the allegedly inadequate payment rates received by Provider Plaintiffs are fairly traceable to HHSC's actions and that it is not too speculative to conclude that a favorable decision would result in higher rates. Low rates themselves are the injury to Provider Plaintiffs. Therefore, the Court is not required to engage in the same speculation required in its causation and redressability analysis of Recipient Plaintiffs' injuries. Thus, Provider Plaintiffs have properly asserted standing with respect to their claims that they perform medical services for inadequate rates.

Appendix B

2. Provider Plaintiffs' Third-Party Standing

As discussed above, Provider Plaintiffs have alleged an injury-in-fact to themselves, namely, inadequate payment rates. Additionally, Defendant does not contest the fact that Provider Plaintiffs have a close relationship with their patients. Therefore, the only remaining issue for the Court to decide is whether there exists some hindrance to Provider Plaintiffs' patients' abilities to protect their own interests. *Powers*, 499 U.S. at 410, 111 S.Ct. 1364. This inquiry requires the Court to examine "the likelihood and ability of the third parties . . . to assert their own rights." *Id.* at 414, 111 S.Ct. 1364.

Provider Plaintiffs allege that "the vast majority of their Medicaid recipient patients do not have access to the level of information necessary to assert their rights, and even if they did have such information, they lack the resources to assert their rights." Pls.' First Am. Compl., at 14, ¶ 30. This assertion is a mere legal conclusion that is insufficient to support third-party standing. *See Fernandez-Montes v. Allied Pilots Ass'n*, 987 F.2d 278, 284 (5th Cir.1993) (stating that "conclusory allegations or legal conclusions masquerading as factual conclusions will not suffice to prevent a motion to dismiss"). Provider Plaintiffs do not allege what *kind* of information Provider Plaintiffs have that their patients lack. In contrast, in *Clayworth* the Medicaid providers, who were suing to enjoin a state-wide rate cut of 5%, specifically alleged that they were the ones "who [knew] the relationship of reimbursement to service and to their costs." *Clayworth*, 295 F.Supp.2d at 1118. As a result,

the providers in *Clayworth* were "in a far better position to evaluate the State's decisional process and the data relied upon by the State in determining reimbursement rates." *Id.*

The only cognizable claim any plaintiffs assert is Recipient Plaintiffs' claim that HHSC's payment rates violate the Equal Access Provision of the Medicaid Act. *See infra* Part III (analyzing Plaintiffs' claims to determine whether they survive Defendant's Rule 12(b)(6) motion to dismiss). Unlike the providers in *Clayworth*, Provider Plaintiffs do not allege that they are in a better position to compare the access to medical services of Medicaid recipients in El Paso with the access of the general population in El Paso. *See infra* Part III(B)(2) (explaining the nature of a cognizable Equal Access Provision claim).

Additionally, the bare assertion that patients lack resources is insufficient, in and of itself, to establish third-party standing. *Cf. Powers*, 499 U.S. at 415, 111 S.Ct. 1364 (noting several specific "practical barriers to suit by the [third-party jurors whose interests the plaintiffs seek to represent]" such as the difficulty "for an individual juror to show a likelihood that discrimination against him at the voir dire stage will recur"). Simply put, Provider Plaintiffs have provided the Court with no significant information about the likelihood and abilities of Provider Plaintiffs' patients to assert their own rights. In fact, the claims in this case brought by several El Paso Medicaid recipients (and an organization partially comprised of Medicaid recipients)

undermine the argument that Medicaid recipients do not have the incentive or ability to bring claims on their own behalf. Therefore, prudential considerations require the Court to hold that Provider Plaintiffs have not established standing to assert any claims on behalf of their patients.

D. Equal Access's Standing to Sue

The Court finds that Equal Access has alleged sufficient facts to establish standing pursuant to the three *Hunt* factors. Under the first *Hunt* factor, to establish associational standing Equal Access must allege that the members of its organization would otherwise have standing to sue in their own right. *Hunt*, 432 U.S. at 343, 97 S.Ct. 2434. Plaintiff Equal Access seeks to sue "on behalf of its members, many of whom are Medicaid recipients and health care professionals and other providers who are directly and adversely impacted by HHSC's actions, and on behalf of the its [sic] member health care professionals' and providers' patients." Pls.' First Am. Compl., at 10, ¶ 5. The Court has found that Recipient Plaintiffs have standing to challenge their access to medical services resulting from allegedly inadequate Medicaid payment rates.[20] It has also determined that Provider Plaintiffs have standing to challenge the allegedly inadequate payment rates they receive.[21] Equal Access alleges that its members include

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20. *See supra* Part II(B) (discussing the standing of Recipient Plaintiffs).

21. *See supra* Part II(C)(1) (discussing the standing of Plaintiff Recipients to sue on their own behalf).

those who have suffered the same injuries as Recipient Plaintiffs and Provider Plaintiffs. Pls.' First Am. Compl., at 10, ¶ 5. Therefore, Equal Access satisfies the first *Hunt* factor.

Under the second *Hunt* factor, the interests Equal Access seeks to protect in bringing its claims must be germane to the organization's purpose. *Hunt*, 432 U.S. at 343, 97 S.Ct. 2434. Equal Access alleges that "[t]he purpose of Plaintiff Equal Access is to develop health care resources and access to health care in El Paso County." Pls.' First Am. Compl., at 10, ¶ 5. Recipient Plaintiffs sue to remedy the alleged injury of a lack of access to medical services. The interest of access to medical services is Equal Access's stated goal. Therefore, Equal Access satisfies the second *Hunt* factor.

Under the third *Hunt* factor, Equal Access must show that neither the claims it asserts nor the relief it requests requires the participation of its individual members. *Hunt*, 432 U.S. at 343, 97 S.Ct. 2434. In *Clayworth*, the court granted associational standing in part because "no showing on damages" and no "individual proof by beneficiary members" would be required. *Clayworth*, 295 F.Supp.2d at 1119. Similarly, in the instant case Medicaid recipients and providers do not seek individualized damages. Rather, they seek injunctive and declaratory relief. Additionally, Plaintiffs' claims will not necessarily require the proof of individual

Medicaid recipients and providers.[22] Therefore, Equal Access satisfies the third *Hunt* factor. Thus, the Court finds that Plaintiff Equal Access satisfies the three *Hunt* factors and has standing to sue on behalf of its member Medicaid recipients and providers.

E. Plaintiffs' Standing to Assert Their Supremacy Clause Claim

Plaintiffs' Supremacy Clause claim alleges that both (1) HB1 of the 78th Texas Legislature (the General Appropriations Act) and (2) HHSC's "regulations, policies, practices and procedures for administering Medicaid services in El Paso County" violate the Supremacy Clause of the U.S. Constitution. Pls.' First Am. Compl., at 25, ¶ 63. Plaintiffs seek relief for these alleged violations "under 42 U.S.C. § 1983." *Id.* at 26, ¶ 64. The Court will analyze each claim in turn to

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22. For example, Plaintiffs' claim under the Equal Access Provision, the only part of the Medicaid Act pursuant to which the Court ultimately concludes Plaintiffs have stated a claim, requires a comparison between the access of Medicaid and non-Medicaid recipients to medical services in the El Paso area. Although individual instances of a lack of access to services might be helpful, it would not be absolutely necessary in such a comparison. At the very least, no fact-specific inquiry into individual instances of a lack of access to medical services will be required. *Cf. Comm. for Reasonable Regulation of Lake Tahoe v. Tahoe Reg'l Planning Agency*, 365 F.Supp.2d 1146, 1163 (D.Nev.2005) (finding that the association failed the third *Hunt* test because a "fact-specific" analysis of the association's members would be required).

determine if Plaintiffs have adequately established standing.

1. House Bill 1

Plaintiffs allege that HB1 violates the Supremacy Clause in that it conflicts with several provisions of the Medicaid Act.[23] In *Planned Parenthood of Houston & Southeast Tex. v. Sanchez*, 403 F.3d 324 (5th Cir.2005), the Fifth Circuit recognized a claim that Rider 8 to the Texas General Appropriations Act was preempted by the Medicaid Act. Unlike the *Planned Parenthood* plaintiffs, the plaintiffs in the instant case do not allege that a specific portion of HB1 conflicts with the Medicaid Act.[24]

The U.S. Supreme Court has stated that "state law is nullified to the extent that it actually conflicts with federal law." *Fidelity Federal Sav. & Loan Ass'n v. de la Cuesta*, 458 U.S. 141, 152, 102 S.Ct. 3014, 73 L.Ed.2d 664 (1982). Plaintiffs' Supremacy Clause claim would result in a partial nullification of HB1 to the extent that

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23. This challenge to HB1 appears to be limited to Plaintiffs' Supremacy Clause claim.

24. Plaintiffs' complaint makes reference to "[l]ine items B.2.1 through B.2.8 of the Medicaid Budget." Pls.' First Am. Compl., at 19, ¶ 39. However, this appears to be a reference to "Legislative Budget Board Recommendations," rather than to HB1. *See* Def. Albert Hawkins's Mot. to Dismiss (hereinafter "Original Mot. to Dismiss"), App. A. (showing that B.2.1 through B.2.8 are Medicaid program spending recommendations made by the Legislative Budget Board).

it sets inadequate payment rates. *Id.* However, unlike the plaintiffs claiming a conflict with the Medicaid Act in *Planned Parenthood,* Plaintiffs have not identified a portion of HB1, which, if nullified, would redress their alleged injuries.[25] Furthermore,*608 it is purely speculative whether the legislature would appropriate more money in the future as a result of the nullification of some unspecified portion of HB1. *See Henderson v. Stalder,* 287 F.3d 374, 381 (5th Cir.2002) (holding that a plaintiff lacked standing to challenge the funding to the "Choose Life" message because even it was declared unconstitutional, the plaintiff's "complained of injury would not be redressed as that remedy will not provide [the plaintiff] a forum in which to express her pro-choice viewpoint").

In fact, Plaintiffs state that they are not "asking for abrogation of HB1." Pls.' Joint Resp. to Def. Albert Hawkins' Am. Mot. to Dismiss (hereinafter "Joint Resp."), at 9, ¶ 24. Plaintiffs' actual grievance appears to be directed at the manner in which HHSC *implements* HB1, rather than at the legislature's appropriation of resources to Medicaid. *See* Pls.' First Am. Compl., at 19, ¶ 39 (stating that "Defendant is ultimately responsible for implementing these Acts of the Legislature by setting the Medicaid budget for the Texas Health and Human Services Commission"); Joint Resp., at 10, ¶ 24 (responding to Defendant's contention that Plaintiffs'

25. Similarly, Plaintiffs' complaint fails to show how any portion of HB1 has caused their injuries. Therefore, the Court has no way to determine whether Plaintiffs' injuries are fairly traceable to HB1.

challenge to portions of HB1 would result in the nullification of those portions by restating their claims that Texas "must *administer* a state plan that meets federal requirements") (emphasis added). Plaintiffs have neither adequately specified which portions of HB1 violate the Medicaid Act, nor have they shown how the nullification of a portion of HB1 is likely to redress any of their alleged injuries. Furthermore, Plaintiffs do not seek the nullification of a portion of HB1. Therefore, Plaintiffs have failed to meet their burden of establishing standing for their claim that HB1 violates the Medicaid Act.

2. HHSC's Implementation of Medicaid

In addition to challenging HB1, Plaintiffs also allege that HHSC's "regulations, policies, practices and procedures for administering Medicaid services in El Paso" violate the Supremacy Clause. Pls.' First Am. Compl., at 25, ¶ 73. Specifically, Plaintiffs allege that HHSC's setting of low payment rates violates the Medicaid Act. As discussed above, the Court has determined that Plaintiffs' have suffered injuries-in-fact that are fairly traceable to HHSC's setting of rates, the same injuries and conduct challenged by Plaintiffs' Supremacy Clause claim. *See supra* Part II(B)(2), (C)(1) (explaining why Recipient Plaintiffs and Provider Plaintiffs meet the first two prongs of Article III standing). Additionally, if Plaintiffs are successful, it is not too speculative to determine that a declaration of the invalidity of HHSC's practices would result in the redress of Plaintiffs' alleged injuries, a lack of access to

medical services in the case of Recipient Plaintiffs, and the receipt of payment for services provided at inadequate rates in the case of Provider Plaintiffs. *See supra* Part II(B)(3), (C)(1) (explaining why Recipient Plaintiffs and Provider Plaintiffs meet the requirements of constitutional redressability).[26] Therefore, Plaintiffs have standing to allege that HHSC's implementation of Medicaid violates the Supremacy Clause in that it is inconsistent with certain provisions of the Medicaid Act. Having determined that Recipient Plaintiffs, Provider Plaintiffs, and Plaintiff Equal Access have standing, the Court will proceed to examine Defendant's Motion to Dismiss pursuant to Rule 12(b)(6).

III. DEFENDANT'S RULE 12(b)(6) MOTION

Plaintiffs sued and seek recovery under six separate provisions of the Medicaid Act, the Equal Protection clause of the U.S. Constitution, and the Supremacy Clause of the U.S. Constitution. Defendant alleges (1) that the Medicaid Act provisions do not create a private right of action and (2) that each of Plaintiffs' eight counts fails to state a cognizable claim.

A. Analytical Standard

1. 12(b)(6) Standard Generally

Rule 12(b)(6) permits the dismissal of a complaint if it "fail[s] to state a claim upon which relief can be granted." Fed. R. Civ. P. 12(b)(6). When presented with

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26. A favorable decision under Plaintiffs' Supremacy Clause claim would likely have the same effect as its § 1983 claim alleging a violation of the Equal Access Provision.

a Rule 12(b)(6) motion, the Court must accept all well-pleaded facts in the complaint as true and construe all reasonable inferences in the light most favorable to the plaintiff. *Baker v. Putnal*, 75 F.3d 190, 196 (5th Cir.1996). A plaintiff must plead specific facts in his complaint; conclusory allegations are insufficient to survive a Rule 12(b)(6) motion to dismiss. *See Kaiser Aluminum & Chemical Sales, Inc. v. Avondale Shipyards, Inc.*, 677 F.2d 1045, 1050 (5th Cir.1982) (citing *Associated Builders, Inc. v. Ala. Power Co.*, 505 F.2d 97, 100 (5th Cir.1974)) (stating that "we do not accept as true conclusionary allegations in the complaint"). The Court then must determine whether the facts alleged, if true, would entitle the plaintiff to some form of relief. *Harris v. Hegmann*, 198 F.3d 153, 156 (5th Cir.1999). Importantly, a Rule 12(b)(6) motion "tests only the formal sufficiency of the statements of the claims for relief. It is not a procedure for resolving contests about the facts or the merits of the case." *Jolly v. Klein*, 923 F.Supp. 931, 942 (S.D.Tex.1996). Thus, "[n]ormally, in deciding a motion to dismiss for failure to state a claim, courts must limit their inquiry to the facts stated in the complaint and the documents either attached to or incorporated in the complaint." *Lovelace v. Software Spectrum Inc.*, 78 F.3d 1015, 1017 (5th Cir.1996).

Rule 12(b)(6) motions are "viewed with disfavor and [are] rarely granted." *Kaiser*, 677 F.2d at 1050. The Court may dismiss a complaint pursuant to Rule 12(b)(6) only if it is convinced that the plaintiff cannot prove any set of facts in support of his claim that would entitle him to relief. *Hishon v. King & Spalding*, 467 U.S. 69, 73, 104

S.Ct. 2229, 81 L.Ed.2d 59 (1984). Specifically, the Court may dismiss a complaint pursuant to Rule 12(b)(6) only if it finds "either (1) 'the lack of a cognizable legal theory' or (2) 'the absence of sufficient facts alleged under a cognizable legal theory.' " *Meador v. Oryx Energy Co.*, 87 F.Supp.2d 658, 661 (E.D.Tex.2000) (citing *Balistreri v. Pacifica Police Dep't*, 901 F.2d 696, 699 (9th Cir.1988)). At some level, the facts alleged must relate to the legal theories pled by a plaintiff or otherwise allege a claim based on a cognizable, though perhaps unstated, legal theory. *See In re Colonial Mortgage Bankers Corp.*, 324 F.3d 12, 15 (1st Cir.2003) (noting that in applying the Rule 12(b)(6) standard, "[the court] assume[s] the truth of all well-pleaded facts and indulge[s] all reasonable inferences that fit the plaintiff's stated theory of liability"); *see also Ramming v. United States*, 281 F.3d 158, 162 (5th Cir.2001) ("[W]hen considering a Rule 12(b)(6) motion to dismiss for failure to state a claim, the district court must examine the complaint to determine whether the allegations provide relief on any possible theory.").

With respect to Plaintiffs' claims under the Medicaid Act, Defendant argues that Plaintiffs have failed to state a cognizable legal theory because the provisions of the Medicaid Act pursuant to which Plaintiffs have sued do not create private rights of action. With respect to all of Plaintiffs' claims, Defendant argues that Plaintiffs' complaint does not state a cognizable claim because the facts alleged do not support a cognizable legal theory.

2. *The Standard for Determining if a Statute Confers a Private Right of Action*

In order to state a cognizable legal theory, plaintiffs must demonstrate that the law provides them both a right and a remedy. Section 1983 provides a remedy to vindicate certain federal rights by providing for liability against "[e]very person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws." 42 U.S.C. § 1983. Section 1983's provision for liability extends to rights conferred by federal statutes. *Maine v. Thiboutot,* 448 U.S. 1, 12-13, 100 S.Ct. 2502, 65 L.Ed.2d 555 (1980). However, § 1983 requires a plaintiff to assert a "violation of a federal *right,* not merely a violation of federal *law.*" *Blessing v. Freestone,* 520 U.S. 329, 340, 117 S.Ct. 1353, 137 L.Ed.2d 569 (1997).

In determining whether a particular federal statutory provision gives rise to a federal right, courts traditionally look at the following three factors:

> First Congress must have intended that the provision in question benefit the plaintiff. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so "vague and amorphous" that its enforcement would strain judicial competence.

> Third, the statute must unambiguously impose a binding obligation on the States. In other words, the provision giving rise to the asserted right must be couched in mandatory, rather than precatory, terms.

Id. at 340-41, 117 S.Ct. 1353 (internal citations and quotations omitted). Recently, the Supreme Court has clarified the traditional *Blessing* analysis by emphasizing that actions brought under § 1983 require nothing "short of an unambiguously conferred right." *Gonzaga Univ. v. Doe*, 536 U.S. 273, 283, 122 S.Ct. 2268, 153 L.Ed.2d 309 (2002). The *Gonzaga* Court rejected the view of some courts "allowing plaintiffs to enforce a statute under § 1983 so long as the plaintiff falls within the general zone of interest that the statute is intended to protect." *Id.* In other words, it is "*rights*, not the broader or vaguer 'benefits' or 'interests,' that may be enforced under the authority of that section." *Id.*

The *Gonzaga* Court held that the Supreme Court's "implied right of action cases should guide the determination of whether a statute confers rights enforceable under § 1983." *Id.* The initial inquiry "is to determine whether or not a statute 'confers rights on a particular class of persons.' " *Id.* at 285, 122 S.Ct. 2268 (quoting *California v. Sierra Club*, 451 U.S. 287, 294, 101 S.Ct. 1775, 68 L.Ed.2d 101 (1981)). Critical to this determination is an inquiry into whether the statute contains "rights-creating language." *Id.* at 284, 122 S.Ct. 2268. As an example of such a statute, the *Gonzaga* Court proffered Title IX of the Education Amendments of 1972,

which states: "*No person* in the United States *shall*, on the basis of sex, . . . be subjected to discrimination under any education program or activity receiving Federal financial assistance." *Id.* (quoting 20 U.S.C. § 1681(a)) (emphasis in *Gonzaga*). The *Gonzaga* Court emphasized that Title IX is "phrased in terms of the person benefitted." *Id.*

If a plaintiff establishes that a statute creates a federal right, "the State may rebut this presumption by showing that Congress 'specifically foreclosed a remedy under § 1983.' " *Id.* at 285 n. 4, 122 S.Ct. 2268 (quoting *Smith v. Robinson*, 468 U.S. 992, 1004-05, 104 S.Ct. 3457, 82 L.Ed.2d 746 (1984)). The state can meet this burden "either expressly, through specific evidence from the statute itself," or it can do so "impliedly, by creating a comprehensive enforcement scheme that is incompatible with individual enforcement under § 1983." *Id.* at 284, 122 S.Ct. 2268 (internal quotations and citations omitted). Therefore Plaintiffs must initially demonstrate that Congress unambiguously conferred a federal right in every provision of the Medicaid Act under which Plaintiffs attempt to sue.

B. The Equal Access Provision

1. Private Right of Action

Plaintiffs' first count asserts a claim under the Equal Access Provision, contained in § 30(A) and its

implementing regulation, 42 C.F.R. 447.204.[27] The Equal Access Provision requires a state plan to provide for procedures, including those related to payment, which are "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services care available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30)(A). The Court will analyze whether the Equal Access Provision creates a private right of action for the benefit of each class of plaintiffs in turn.

a. Right of Action for Recipient Plaintiffs [28]

In *Evergreen*, the Fifth Circuit held that the Equal Access Provision of the Medicaid Act creates a federal

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27. The Court need not separately analyze whether the implementing regulation creates a private right of action. *See Bryson v. Shumway*, 177 F.Supp.2d 78, 92 (D.N.H.2001) (holding that an implementing regulation cannot create a private right of action unless the statute which it seeks to enforce creates a private right of action). However, an implementing regulation can be useful to further define and flesh out the meaning of a statute. *See id.* (explaining that "so long as the statute itself confers a specific right upon the plaintiff, and a valid regulation merely further defines or fleshes out the content of that right, then the statute—in conjunction with the regulation-may create a federal right as further defined by the regulation") (internal quotations and citations omitted).

28. This analysis also applies to Plaintiff Equal Access to the extent it is suing on behalf of its members who are Medicaid recipients.

right in favor of Medicaid recipients that is enforceable under § 1983. *Evergreen*, 235 F.3d at 927. However, *Evergreen* was decided before the Supreme Court's decision in *Gonzaga*, a case which clarified the standard for determining whether a federal statute creates a private right of action.[29] As a result, Defendant asks the Court to reevaluate the Fifth Circuit's decision in *Evergreen* in light of *Gonzaga's* holding that a statute must "unambiguously" confer a federal right upon plaintiffs to be enforceable under § 1983. *Gonzaga*, 536 U.S. at 300, 122 S.Ct. 2268.

The Court will not disregard *Evergreen*, which it recognizes as a binding precedent, unless it is clear that *Evergreen's* holding conflicts with the intervening *Gonzaga* opinion. *See Fujian Mach. & Equip. Imp. & Exp. Corp. v. United States*, 178 F.Supp.2d 1305, 1313 (stating that "a trial court may not disregard the controlling precedent of its appellate court where an intervening Supreme Court decision merely casts doubt on the continuing viability of that precedent, rather than directly overruling it"). To make this determination, it is necessary to analyze the basis of the Fifth Circuit's

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29. Although the Fifth Circuit has not had an occasion to revisit *Evergreen*, it has given at least some indication that it still considers *Evergreen* to be good law. In *S.D. v. Hood*, 391 F.3d 581, 605 (5th Cir.2004), the Fifth Circuit cited with approval its finding in *Evergreen* that the "the 'equal access' mandate of § 1396a(a)(30)(A) is not too vague to be enforceable." However, this mention of *Evergreen* merely affirms the Fifth Circuit's previous finding regarding the second factor in *Blessing*, a factor not directly impacted by *Gonzaga*.

decision in *Evergreen* and the impact of *Gonzaga* on the decision.

The *Evergreen* court based its decision on an analysis of the three factors articulated in *Blessing*. The first *Blessing* factor, whether Congress intended that the provision in question benefit the plaintiff, was the factor most directly impacted by *Gonzaga*. In the *Evergreen* court's analysis of the first *Blessing* factor, the court found that Medicaid recipients were the intended beneficiaries of the Equal Access Provision. *Evergreen*, 235 F.3d at 927-28. The court emphasized that Medicaid recipients are "intended *beneficiaries* of section 30(A) because the provision is 'phrased in terms' *benefitting* recipients." *Id.* at 927 (emphasis added) (quoting *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 510, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990)).

The *Evergreen* court's focus on the intended benefit of a statute appears typical of the looser "benefit" or "zone of interest" standard that the Supreme Court teaches against in *Gonzaga*. *Gonzaga*, 235 F.3d at 283 (rejecting "a relatively loose standard" that would conclude that a statute confers a federal right "so long as Congress intended that the statute 'benefit' putative plaintiffs"). Notably absent from the court's discussion is an analysis of whether § 30(A) contains "rights-creating language," language which the *Gonzaga* Court describes as "critical to showing the requisite

congressional intent to create new rights." *Id.* at 287, 122 S.Ct. 2268.[30]

However, although at first blush the *Evergreen* decision appears to apply the looser "benefit" standard, there are some indications in the decision that the Fifth Circuit was applying a the more rigorous analysis required by *Gonzaga*. For example, the Fifth Circuit recognized that *Wilder*, which found that the Medicaid Act conferred a private right, was narrowed by subsequent cases, such as *Suter v. Artist M.*, 503 U.S. 347, 112 S.Ct. 1360, 118 L.Ed.2d 1 (1992), and *Blessing*, and that "Congress must unambiguously confer through section 30(A) an 'individual entitlement' upon each of the plaintiffs in the case." *Evergreen*, 235 F.3d at 926-27 (quoting *Blessing*, 520 U.S. at 343, 117 S.Ct. 1353). The

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30. Strengthening Defendant's argument that the Fifth Circuit is likely to overturn *Evergreen's* holding that § 30(A) confers a federal right on Medicaid recipients is the fact that "[s]ince *Gonzaga*, no federal court of appeals . . . has concluded that § 30(A) provides Medicaid recipients or providers with a right enforceable under § 1983." *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir.2005). In *Sanchez*, the Ninth Circuit recently considered whether § 30(A) confers a private right of action upon Medicaid beneficiaries. *Id.* The *Sanchez* court held that § 30(A) failed the first prong of the *Blessing* test because (1) the language of § 30(A) has an aggregate rather than an individual focus; and (2) "the flexible, administrative standards embodied in the statute do not reflect a Congressional intent to provide a private remedy for their violation." *Id.* at 1059. *See also supra* note 17 (explaining that the Equal Access Provision is results-oriented, which militates against a finding that Congress intended it to confer a private right of action).

Gonzaga Court cites *Suter* as a case that foreshadowed the principle made clear in *Gonzaga*, namely, that the Supreme Court's "implied right of action cases should guide the determination of whether a statute confers rights enforceable under § 1983." *Gonzaga*, 536 U.S. at 283, 122 S.Ct. 2268. Therefore, the Fifth Circuit's acknowledgment that *Suter* narrowed *Wilder* indicates that it was not applying the "loose" benefit standard implicated by *Wilder*. Furthermore, the *Evergreen* court clarified that it must determine whether the Medicaid statute "confers a federal *right* on each of the plaintiffs in the case." *Evergreen*, 235 F.3d at 927 (emphasis added). Requiring that a statute confer a right, instead of merely a benefit, also suggests that the court's analysis in *Evergreen* does not conflict with *Gonzaga*. Thus, the Court finds that *Gonzaga* does not clearly conflict with *Evergreen*.

As a result of the fact that *Gonzaga* neither explicitly overturns nor clearly conflicts with *Evergreen*, the Court finds that *Evergreen* remains binding precedent on the Court. As a result, the Court finds that the Equal Access Provision of § 30(A) confers a private right of action upon Recipient Plaintiffs.

b. Right of Action for Provider Plaintiffs [31]

In *Evergreen*, the Fifth Circuit explicitly held that the Equal Access Provision does not create a private

31. This analysis also applies to Plaintiff Equal Access to the extent it is suing on behalf of its members who are Medicaid providers.

right of action for Medicaid Providers. No subsequent case law casts doubt upon this conclusion. In fact, *Gonzaga* only strengthens the *Evergreen* court's conclusion because the Equal Access Provision contains no rights-creating language with respect to Medicaid providers. Therefore, the Court finds that Provider Plaintiffs do not have a private right of action under the Equal Access Provision.

2. Cognizable Claim

[26] Defendant argues that even if the Equal Access Provision confers a private right of action, Plaintiffs' alleged facts do not state a cognizable claim. Throughout Plaintiffs' complaint, Plaintiffs allege that certain medical services are simply unavailable in El Paso. For example, Plaintiffs point out that one Recipient Plaintiff, Ms. Melendez, alleges that her lack of access to medical services "stems from [a] lack of physicians and therapists in the El Paso Area." Pls.' First Am. Compl., at 10, ¶ 25.

The plain language of the Equal Access Provision does not require a certain level of medical professionals in an area; it only requires a certain relationship between the level of providers available to Medicaid recipients and the level of providers available to the general population. *See Clark*, 339 F.Supp.2d at 644 (quoting the legislative history of the Equal Access Provision in stating that "the Committee bill would not require that Medicaid payment levels be high enough to induce physicians to relocate into this area") (quoting H.R.Rep. No. 101-247, at 390-91, *reprinted in* 1989

U.S.C.C.A.N.1906, 2116-17). To illustrate, if no pediatric surgeon is available in El Paso to serve the general population, then it is not possible to assert an Equal Access Provision claim on that basis. However, if a pediatric surgeon is available to serve insured patients but not to provide services to Medicaid recipients, then an Equal Access Provision claim is possible. Thus, Defendant's allegation of a lack of Medicaid providers in El Paso, standing alone, fails to state a claim under the Equal Access Provision.

However, Plaintiffs point out that Ms. Melendez also alleges that her problems stem from "the lack of physicians and therapists willing to accept Medicaid [and] the number of physicians and therapists who have had to curtail their participation in Medicaid." Pls.' First Am. Compl., at 10, ¶ 25. Ms. Melendez also alleges that "[w]omen and children in El Paso covered by traditional insurance have better access to healthcare" than she does.[32] *Id.* The allegation that access to medical services in El Paso is not *equal* does state a cognizable legal theory under the Equal Access Provision. Furthermore, as long as Plaintiffs state one cognizable legal theory, it is not proper to dismiss their claim under the Equal Access Provision. *See Haddock v. Bd. of Dental Examiners of Calif.*, 777 F.2d 462, 464 (9th Cir.1985)

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32. This dual allegation of an overall lack of providers in El Paso and a lack of providers willing to accept Medicaid is typical of Recipient Plaintiffs' claims. *See, e.g.*, Pls.' First Am. Compl., at 10, ¶ 26 (alleging both "a lack of physicians and dentists in the El Paso area" and "the lack of physicians and dentists willing to accept Medicaid").

(stating that "a complaint should not be dismissed if it states a claim under any legal theory, even if the plaintiff erroneously relies on a different legal theory").

Defendant's second argument is that Plaintiffs do not claim that they have been denied services, but rather that services have been delayed. Def. Albert Hawkins' Am. Mot. to Dismiss (hereinafter "Am. Mot. to Dismiss"), at 19. Defendant argues that the Equal Access Provision does not grant "recipients a right to speedy delivery of services." *Id.* However, long waits constitute at least some evidence that services are not available to Medicaid recipients in El Paso to the extent that services are available to the general population.[33] *See Clark*, 339 F.Supp.2d at 644 (stating that the plaintiffs could demonstrate unequal access through "reports that recipients are having difficulty obtaining care"). Moreover, Plaintiffs also argue that certain services are not available at all that are available to the general population. *See* Pls.' First Am. Compl., at 10, ¶ 25 (alleging that one Recipient Plaintiff is unable to receive medical and therapeutic services for her children because they are unavailable to her in El Paso *"from a Medicaid provider"* and that "women and children in El Paso covered by traditional insurance have better access to healthcare") (emphasis added). Thus, Plaintiffs' alleged facts support at least one valid legal theory under

33. Of course, the evidence is only relevant if combined with evidence that the general population is not required to endure similar long waits for similar services.

the Equal Access Provision, and their claims under it cannot it be dismissed for failing to state a cognizable claim.

C. The Quality of Care Provision

1. Private Right of Action

In addition to containing the Equal Access Provision, § 30(A) contains language, which the Court will refer to as the "Quality of Care Provision," that requires a state plan to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . to assure that payments are consistent with efficiency, economy, and quality of care." 42 U.S.C. § 1396a(a)(30)(A). Unlike the Equal Access Provision, the Fifth Circuit has not explicitly addressed whether the Quality of Care Provision creates a private right of action for Medicaid recipients or providers. The *Evergreen* case only examined the Equal Access Provision portion of § 30(A). *Evergreen*, 235 F.3d at 927 n. 24. Therefore, this Court must make an independent determination of whether the Quality of Care Provision confers a private right of action upon each class of plaintiffs based on the *Blessing* factors as clarified by *Gonzaga*.

Appendix B

a. Right of Action for Recipient Plaintiffs[34]

To begin, an analysis of the Quality of Care Provision under the *Blessing* factors, as clarified by *Gonzaga*, differs from an analysis of the Equal Access Provision. With respect to the first *Blessing* factor, the Quality of Care Provision does not as clearly benefit Medicaid recipients as does the Equal Access Provision. To illustrate, the *Evergreen* court found Medicaid recipients are the intended beneficiaries of the Equal Access Provision because "the provision is 'phrased in terms' benefitting recipients in that it directly focuses on their access to medical care." *Evergreen*, 235 F.3d at 927 (quoting *Wilder*, 496 U.S. at 510, 110 S.Ct. 2510). The *Evergreen* court further clarifies that "section 30(A) speaks clearly in terms of the recipients because 'care and services' are [to be] available under the [state] plan at least to the extent that such care and services are available to the general population in the geographic area." *Id.* When compared to the Equal Access Provision, which clearly calls for an analysis of the extent of care available to individuals, the Quality of Care Provision does not as clearly implicate individual Medicaid recipients. The Quality of Care Provision makes no mention of "care and services" which must be "available,"

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34. This analysis also applies to Plaintiff Equal Access to the extent it is suing on behalf of its members who are Medicaid recipients.

clearly implying care and services available to individual recipients.[35]

Additionally, *Gonzaga's* clarification of the first *Blessing* factor strengthens the Court's conclusion that the Quality of Care Provision does not unambiguously confer a right on Medicaid recipients. In particular, the Quality of Care Provision lacks the kind of rights-creating language that *Gonzaga* defines as "critical" to determining Congress's intent to create a right. *Gonzaga*, 536 U.S. at 287, 122 S.Ct. 2268. As the *Sanchez* court noted, § 30(A) has an aggregate focus, in that the statute "speaks not of any individual's right but of the State's obligation to develop 'methods and procedures' for providing services generally." *Sanchez*, 416 F.3d at 1059.[36] The *Sanchez* court concluded that "[a] statutory provision that refers to the individual only in the context of describing the necessity of developing state-wide policies and procedures does not reflect clear Congressional intent to create a private right of Action." *Id.*

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35. If it mirrored the Equal Access Provision, the Quality of Care Provision would state that "payments must be sufficient to ensure quality care is available."

36. The Court acknowledges that this analysis also applies to the Equal Access Provision. However, as discussed above, the Court is bound by *Evergreen* to find that the Equal Access Provision creates a private right of action. *See supra* Part III(B)(1)(a) (explaining that *Gonzaga* merely cast doubt on the Fifth Circuit's determination in *Evergreen*).

Because the Court finds that the Quality of Care Provision does not satisfy the first requirement of *Blessing*, it is not necessary to analyze the other factors.[37] Thus, the Court finds that the Quality of Care provision does not confer a private right of action upon Recipient Plaintiffs.

b. Right of Action for Provider Plaintiffs[38]

Although the *Evergreen* court did not address the Quality of Care Provision, its Equal Access Provision analysis is helpful in determining whether it would find that the Quality of Care Provision confers a federal right on Medicaid providers. In *Evergreen*, the court held that the Equal Access Provision does not confer a private right of action upon Medicaid providers because § 30(A) "does not focus directly on providers." *Evergreen*, 235 F.3d at 929. The *Evergreen* court also noted that the courts that *did* construe the Equal Access Provision to

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37. The Court also notes that, under the second *Blessing* factor, the Quality of Care provision is more "vague and amorphous" than the Equal Access Provision because it does not contain the "measuring rod" by which to evaluate quality of care that is contained in the Equal Access Provision. *See Evergreen*, 235 F.3d at 930-31 (noting that the Equal Access Provision allows a court to measure the access of Medicaid recipients against the access of members of the general population).

38. This analysis also applies to Plaintiff Equal Access to the extent it is suing on behalf of its members who are Medicaid providers.

confer a private right of action relied on the fact that "§ 30(A) speaks of *payments* to these providers." *Id.* (emphasis added). The "payments" requirement also applies to the Quality of Care Provision. Therefore, the Court concludes that the Fifth Circuit would similarly reject the argument that the "payments" language is sufficient to support a finding that the Qualify of Care Provision creates a private of right of action in favor of Medicaid providers.

In addition, the Quality of Care Provision lacks rights-creating language in that it does not mention providers or any rights conferred upon them. *See Gonzaga*, 536 U.S. at 287, 122 S.Ct. 2268 (stating that "rights-creating language" is "critical to showing the requisite congressional intent to create new rights"). Like the Equal Access Provision, the Quality of Care Provision has an aggregate focus on the "methods and procedures" a state must provide. Therefore, the Court determines that the Quality of Care Provision does not confer a private right of action upon Medicaid Providers.

D. The Comparability Provision

1. Private Right of Action[39]

Plaintiffs' second count asserts a claim under, 42 U.S.C. § 1396a(a)(10)(B), which the Court will refer

39. El Paso First does not assert a claim under the Comparability Provision, nor do Provider Plaintiffs on their own behalf. Joint Resp., at 26, ¶¶ 61-62.

to as the "Comparability Provision," and its implementing regulations, 42 C.F.R. §§ 440.230 and 440.240.[40] The Comparability Provision requires the following:

> that the medical assistance made available to any individual described in subparagraph (A)—
>
> (I) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and
>
> (ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A).

42 U.S.C. § 1396a(a)(10)(B). Neither the U.S. Supreme Court nor the Fifth Circuit has addressed whether the Comparability Provision provides a private right of action in favor of Medicaid recipients. Therefore, the Court will analyze whether the Comparability Provision grants a private right of action in favor of Recipient Plaintiffs under the *Blessing* factors, as clarified by *Gonzaga*.

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40. *See supra* note 27 (explaining that: (1) implementing regulations cannot create a federal right if the statutes they are implementing do not confer a right; and (2) the regulations may aid a court in further defining and fleshing out the statutes they implement).

Appendix B

Under the first *Blessing* factor, the Comparability Provision is clearly intended to benefit Medicaid recipients in that it provides for the amount, duration, and scope medical services available to eligible individuals. In addition, the provision includes rights-creating language in that it states that medical services "made available to any *individual*" who is categorically needy "shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual." 42 U.S.C. § 1396a(a)(10)(B) (emphasis added). The provision has a clear focus on the individual rather than an aggregate focus, as required by *Gonzaga*. *Gonzaga*, 536 U.S. at 288, 122 S.Ct. 2268 (noting that the provisions under scrutiny "have an aggregate focus, they are not concerned with whether the needs of any particular person have been satisfied") (internal citations and quotations omitted).

Under the second *Blessing* factor, the Comparability Provision is not so "vague and amorphous" that it would strain judicial competence to enforce it. The provision requires a court "to compare the level of services provided to one recipient with those given another and to determine whether those services are comparable." *Rodriguez v. DeBuono*, 44 F.Supp.2d 601, 611 (S.D.N.Y.1999). This comparison provides courts with an "objective benchmark" in enforcing provisions, namely, the amount, duration, and scope the state provides to other recipients. *See Evergreen*, 235 F.3d at 931 (holding that the Equal Access Provision satisfies the second *Blessing* factor because the provision "affords the 'objective benchmark' of access to medical care equal to

that of the general population in the same geographic area").

Under the third *Blessing* factor, the Comparability Provision uses mandatory, rather than precatory language when it mandates that medical assistance made available to Medicaid recipients "shall not" be less than the medical assistance made available to other recipients. 42 U.S.C. § 1396a(a)(10)(B)(I). *See also Rodriguez*, 44 F.Supp.2d at 611 (finding that the Comparability Provision satisfies the third *Blessing* factor). Therefore, the Comparability Provision satisfies the *Blessing* factors.

Furthermore, Defendant does not contend that Congress has precluded suits under the Comparability Provision, either expressly or through the provision of a comprehensive remedial scheme. *See Golden State Transit Corp. v. Los Angeles*, 493 U.S. 103, 107, 110 S.Ct. 444, 107 L.Ed.2d 420 (1989) (stating that "[t]he burden to demonstrate that Congress has expressly withdrawn the remedy is on the defendant"). Therefore, the Court finds that Congress unambiguously intended the Comparability Provision to confer a federal right on Medicaid recipients.

2. Cognizable Claim

The Comparability Provision sets forth requirements for "medical assistance made available to any individual *described in subparagraph (A)*." 42 U.S.C. § 1396a(a)(10)(B) (emphasis added). "Subparagraph (A)

lists the individuals to whom medical assistance must be provided," referred to as the "categorically needy." *Rodriguez v. City of New York*, 197 F.3d 611, 615 (2d Cir.1999). The categorically needy lack sufficient income to meet their basic needs. *Id.* In contrast to the categorically needy, the "medically needy" are "those who have resources to meet their basic needs but not their medical ones." *Id.* Congress intended the Comparability Provision to ensure that "the primary concern of the states in providing financial assistance should be to meet their basic needs-termed the categorically needy." *Id.* (internal quotations omitted).

The Comparability Provision provides (1) "that if a state elects to provide Medicaid to the medically needy, it must also provide it to the categorically needy and that it may not provide more assistance to the former group than the latter"; and (2) "states may not provide benefits to some categorically needy individuals but not to *618 others." *Rodriguez v. City of New York*, 197 F.3d at 615. In sum, "[§ 1396a(a)(10)(B)] precludes states from discriminating against or among the categorically needy." *Id.*[41] Congress has defined medical assistance

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41. To support this understanding of the Comparability Provision, 42 C.F.R. § 440.250 states that:

> Except as limited in § 440.250—
>
> (a) The plan must provide that the services available to any categorically needy recipient under the plan are not less in amount, duration, and scope than those

(Cont'd)

as " 'payment of part or all of the cost of . . . care and services' included in an enumerated list of twenty-seven general health care categories." *S.D.*, 391 F.3d at 586 (quoting 42 U.S.C. § 1396d(a)).

Thus, stating a claim under the Comparability Provision requires two elements. First, a plaintiff must allege to be categorically needy, as defined by subparagraph 10(A). Second, a plaintiff must allege that the state is providing more favorable medical assistance to other recipients, as Congress defines medical assistance in the statute. Plaintiffs do not specifically claim to be categorically needy as defined by subparagraph 10(A). More importantly, Plaintiffs do not allege that HHSC is making *payments* on behalf of other categorically needy or medically needy recipients which are greater in amount, duration, or scope than payments made on behalf of Recipient Plaintiffs. Additionally, Plaintiffs admit that Medicaid payment schedules of which they complain are in effect statewide. Pls.' First Am. Compl., at 3, ¶ 3. Plaintiffs merely assert that the

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(Cont'd)

services available to a medically needy recipient; and

(b) The plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all recipients within the group:

(1) The categorically needy.

(2) A covered medically needy group.

uniform payment schedules have resulted in long waits in El Paso and the necessity in some circumstances to travel to other geographic areas within Texas where more services are available. They do not allege discrimination in HHSC's payments for the costs of care or services, claims which would fall within the statutory definition of medical assistance. *S.D.*, 391 F.3d at 586.[42] Therefore, Plaintiffs' alleged facts do not state a cognizable claim under the Comparability Provision.

E. The Equity Provision

a. Private Right of Action[43]

Count three of Plaintiffs' complaint alleges causes of action under 42 U.S.C. § 1396a(a)(2), which the Court

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42. A cognizable claim under the Comparability Provision could take several forms. For example, plaintiffs could claim that they are forced to pay for medical services that are provided to other recipients without charge. *See Greenstein v. Bane*, 833 F.Supp. 1054, 1073-74 (S.D.N.Y.1993) (suggesting that such an allegation would state a cognizable claim under the "amount" portion of the Comparability Provision). Also, plaintiffs could claim that "(1) they were denied specific services covered by Medicaid, or (2) they were denied services because defendants decided not to reimburse those recipients who qualified for Medicaid through some other federal program, such as SSI or AFDC." *See id.* at 1073 (suggesting that such an allegation would state a cognizable claim under the "scope" portion of the Comparability Provision).

43. This analysis also applies to Plaintiff Equal Access to the extent it is suing on behalf of its members who are Medicaid recipients and providers.

will refer to as the "Equity Provision." The Equity Provision provides as follows:

> A State plan for medical assistance must—
>
> . . . (2) . . . provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and service available under the plan.

42 U.S.C. § 1396a(a)(2). To the Court's knowledge, neither the U.S. Supreme Court nor the Fifth Circuit has addressed whether the Equity Provision provides a private right of action in favor of Medicaid recipients or providers. Therefore, the Court will determine whether the Equity Provision creates a private right of action in favor of any class of plaintiffs under the *Blessing* factors, as clarified by *Gonzaga*.

Under the first *Blessing* factor, it appears that Congress intended the Equity Provision to benefit Medicaid recipients, if anyone, because it seeks to ensure that the "amount, duration, scope, or quality of care and services under the plan" to Medicaid recipients does not suffer as a result of a lack of adequate funds from local

sources.[44] However, the Equal Access Provision does not contain the rights-creating language which is critical to a conclusion that Congress unambiguously conferred a private right of action upon Medicaid Recipients. *See Gonzaga*, 536 U.S. at 287, 122 S.Ct. 2268 (stating that "rights-creating language" is "critical to showing the requisite congressional intent to create new rights"). The Equity Provision makes no mention of individual Medicaid recipients. Rather, it focuses on the systemwide procedures for allocating funds, which are required to be on an "equalization or other basis." *See id.* at 288, 122 S.Ct. 2268 (noting that the provisions under scrutiny "have an aggregate focus, they are not concerned with whether the needs of any particular person have been satisfied"). Therefore, the Court finds that Congress did not unambiguously intend the Equity Provision to create a private right of action in favor of any plaintiffs.

F. The Statewideness Provision

1. Private Right of Action[45]

The fourth count of Plaintiffs' complaint alleges causes of action under 42 U.S.C. § 1396a(a)(1), which the

44. Therefore, the Court finds that Congress did not intend the Equity Provision to benefit Medicaid providers. Thus, the Court holds that Provider Plaintiffs do not state a claim under the Equity Provision.

45. This analysis also applies to Plaintiff Equal Access to the extent it is suing on behalf of its members who are Medicaid recipients and providers.

Court will refer to as the "Statewideness Provision." The Statewideness Provision provides as follows:

> A State plan for medical assistance must—
>
> (1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them.

42 U.S.C. § 1396a(a)(1). To the Court's knowledge, neither the U.S. Supreme Court nor the Fifth Circuit has addressed whether the Statewideness Provision provides a private right of action in favor of Medicaid recipients or providers. Therefore, the Court will determine whether the Statewideness Provision creates a private right of action in favor of any class of plaintiffs under the *Blessing* factors, as clarified by *Gonzaga*.

Under the first *Blessing* factor, the Statewideness Provision does not clearly confer a benefit on any class of plaintiffs. It does not specifically mention any potential benefits for either Medicaid recipients or providers. Additionally, the Statewideness Provision lacks any "rights creating" language, making no specific mention of either Medicaid recipients or providers. *See Gonzaga*, 536 U.S. at 287, 122 S.Ct. 2268 (stating that "rights-creating language" is "critical to showing the requisite congressional intent to create new rights"). Rather, the Statewideness Provision has an aggregate focus on the administration of a state plan, requiring it to be in effect in and mandatory upon all political subdivisions in a

state. *See id.* at 288, 122 S.Ct. 2268 (noting that the provisions under scrutiny "have an aggregate focus, they are not concerned with whether the needs of any particular person have been satisfied"). Therefore, the Court finds that Congress did not unambiguously intend the Statewideness Provision to create a private right of action in favor of any plaintiffs.

G. The Reasonable Promptness Provision

1. Private Right of Action[46]

Plaintiffs' fifth count asserts a claim under 42 U.S.C. § 1396a(a)(8) and its implementing regulation 42 C.F.R. § 435.930.[47] Title 42 U.S.C. § 1396a(a)(8) provides as follows:

> A State plan for medical assistance must—
>
> . . . (8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and

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46. This analysis also applies to Plaintiff Equal Access to the extent it is suing on behalf of its members who are Medicaid recipients. Provider Plaintiffs do not assert standing under the Reasonable Promptness Provision on their own behalf.

47. *See supra* note 27 (explaining that: (1) implementing regulations cannot create a federal right if the statutes they are implementing do not confer a right; and (2) the regulations may aid a court in further defining and fleshing out the statutes they implement).

> that such assistance shall be furnished with reasonable promptness to all eligible individuals.

Plaintiffs only assert a claim under the second portion of this provision, the portion requiring a state plan to furnish medical assistance with reasonable promptness, to which the Court will refer as the "Reasonable Promptness Provision." To the Court's knowledge, neither the U.S. Supreme Court nor the Fifth Circuit has addressed whether the Reasonable Promptness Provision provides a private right of action in favor of Medicaid recipients or providers. Therefore, the Court will determine whether the Reasonable Promptness Provision creates a private right of action in favor of any plaintiffs under the *Blessing* factors, as clarified by *Gonzaga*.

Under the first *Blessing* factor, the Reasonable Promptness Provision unambiguously confers a benefit on Medicaid recipients, and only on Medicaid recipients, in that it requires a state plan to provide medical assistance with "reasonable promptness *to all eligible individuals.*" 42 U.S.C. § 1396a(a)(8) (emphasis added).[48] Additionally, the Reasonable Promptness Provision contains rights-creating language in that it focuses on "all *individuals* wishing to make application for medical assistance" and on furnishing assistance "to *all eligible*

48. Therefore, the Court finds that Congress did not intend the Reasonable Promptness Provision to benefit Medicaid providers. Thus, the Court holds that Provider Plaintiffs do not state a claim under the Reasonable Promptness Provision.

individuals." Id. (emphasis added). This language is indistinguishable from provisions the *Gonzaga* Court proffered as examples of statutes phrased in terms benefitting individuals. *See Gonzaga,* 536 U.S. at 284, 122 S.Ct. 2268 (providing Title IX of the Education Amendments of 1972 as an example of a statute containing rights-creating language).

Under the second *Blessing* factor, although it is a close question, the Court finds that the Reasonable Promptness Provision is not so vague and amorphous that its enforcement would strain judicial competence. The fact that a statute requires a court to make an inquiry into reasonableness does not in and of itself render a provision too vague. For example, in *Wilder,* the Supreme Court upheld the Medicaid Act's requirement that states adopt Medicaid payment rates that are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." *Wilder,* 496 U.S. at 519-520, 110 S.Ct. 2510. The *Wilder* Court relied on the facts that (1) "the statute and the regulation set out factors which a State must consider in adopting its rates" and (2) the statute provides "the objective benchmark of an 'efficiently and economically operated facilit[y]' providing care in compliance with federal and state standards while at the same time ensuring 'reasonable access' to eligible participants." *Id.* The Reasonable Promptness Provision does not provide a standard against which a court can measure whether a state is administering assistance with reasonable promptness. However, the implementing regulation of the Reasonable Promptness Provision

"further define[s] the contours of the statutory right to reasonably prompt provision of assistance." *Doe v. Chiles*, 136 F.3d 709, 717 (11th Cir.1998). Title 42 C.F.R. § 435.930 provides as follows:

> The agency must—
>
> (a) Furnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures;
>
> (b) Continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible; and
>
> (c) Make arrangements to assist applicants and recipients to get emergency medical care whenever needed, 24 hours a day and 7 days a week.

In addition, 42 C.F.R. § 435.911(a) requires the state to determine eligibility within "[n]inety days for applicants who apply for Medicaid on the basis of disability; and [f]orty-five days for all other applicants." The Court agrees that "[w]hile there may be a range of reasonable [time periods for provision of assistance], there certainly are *some* [time periods] outside that range that no State could ever find to be reasonable . . . under the Medicaid Act." *Doe*, 136 F.3d at 717. Therefore, the Court finds that the Reasonable Promptness Provision, as further fleshed out by its implementing regulations, is not so vague and amorphous that its enforcement would strain judicial competence.

Under the third *Blessing* factor, the Court finds that the Reasonable Promptness Provision unambiguously imposes a binding obligation on the states. Congress drafted the Provision in mandatory, rather than precatory terms, by stating that medical assistance "*shall* be furnished with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8) (emphasis added). *See also Doe,* 136 F.3d at 718 (finding that 1396a(a)(8) is "cast in mandatory rather than precatory terms").

Defendant does not contend that Congress has precluded suits under the Reasonable Promptness Provision, either expressly or through the provision of a comprehensive remedial scheme. *See Golden State,* 493 U.S. at 107, 110 S.Ct. 444 (stating that "[t]he burden to demonstrate that Congress has expressly withdrawn the remedy is on the defendant"). Therefore, the Court finds that Congress unambiguously intended the Reasonable Promptness Provision to confer a private right of action upon Recipient Plaintiffs.

2. Cognizable Claim

The Reasonable Promptness Provision requires a state plan for medical assistance to provide medical assistance "with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8) (emphasis added). Congress has defined medical assistance as " 'payment of part or all of the cost of . . . care and services' included in an enumerated list of twenty-seven general health care categories." *S.D.,* 391 F.3d at 586 (quoting 42 U.S.C.

§ 1396d(a)). Thus, the Reasonable Promptness Provision requires *financial* assistance, not the provision of actual medical *services*. *Bruggeman*, 324 F.3d at 910 (stating that "the statutory reference to 'assistance' appears to have a reference to *financial* assistance rather than to actual medical *services*").[49] In addition, the implementing regulations indicate that "what is required is a prompt determination of eligibility and prompt provision of funds to eligible individuals to enable them to obtain the covered medical services that they need." *Id.* (citing 42 C.F.R. §§ 435.911(a) and .930(a)-(b)). In fact, "a requirement of prompt *treatment* would amount to a direct regulation on medical services." *Bruggeman*, 324 F.3d at 910.

Recipient Plaintiffs claim that low payment schedules have resulted in the reception of medical *services* that are not reasonably prompt. Pls.' First Am. Compl., at 11, ¶ 26 (emphasis added). For example, one Recipient Plaintiff is forced to endure "long waiting periods in health care provider's offices." *Id.* at 10, ¶ 26. Similarly, another Recipient Plaintiff "has been forced to seek services in Dallas on behalf of one child", where such services are readily available for Medicaid Recipients. *Id.* at 10, ¶ 25. However, Plaintiffs do not claim delays in the reception of *financial* assistance. For

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49. Plaintiffs note that at least one court has indicated that the Reasonable Promptness Provision relates to the timeliness of matching a patient to care. *Sabree v. Houston*, 245 F.Supp.2d 653, 661 (E.D.Pa.2003). However, the *Sabree* court's reasoning is unpersuasive because it determined that the Reasonable Promptness Provision did not create a private right of action.

example, Recipient Plaintiffs do not claim delays in the determinations of their eligibility for Medicaid. Thus, Recipient Plaintiffs' alleged facts do not state a cognizable claim under the Reasonable Promptness Provision.

H. The Actuarial Soundness Provision

1. Private Right of Action[50]

Plaintiffs' sixth count asserts a violation of 42 U.S.C. § 1396b(m)(2)(A)(iii), which the Court will refer to as the "Actuarial Soundness Provision." The Actuarial Soundness provision requires the following:

> [N]o payment shall be made under this subchapter to a state with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity (including a health insuring organization) which is responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and any other services described in paragraph (2), (3), (4), (5), or (7) of section 1396d(a) of this title for

50. This analysis also applies to Plaintiff Equal Access to the extent it is suing on behalf of its members who are Medicaid recipients and providers. Provider Plaintiffs Thomason and Dr. Luna do not assert standing under the Actuarial Soundness Provision on their own behalf.

> the provision of any three or more of the services described in such paragraphs unless—
>
> (iii) . . . such services are made on an actuarially sound basis.

Specifically, Plaintiffs contend that HHSC failed to establish capitation rates on an actuarially sound basis. Pls.' First Am. Compl., at 25, ¶ 60. To the Court's knowledge, neither the U.S. Supreme Court nor the Fifth Circuit has addressed whether the Actuarial Soundness Provision confers a private right of action upon Medicaid recipients or providers. Therefore, the Court will determine whether the Actuarial Soundness Provision creates a private right of action in favor of any plaintiffs under the *Blessing* factors, as clarified by *Gonzaga*.

Under the first *Blessing* factor, the Actuarial Soundness Provision does not clearly confer a direct benefit on any class of putative plaintiffs. In finding that the Actuarial Soundness Provision does not confer a right on Medicaid recipients or providers, the *Clayworth* court reasoned as follows:

> By contracting with the State, the managed care plan must guarantee to provide services to recipients. The actuarial soundness provision does not add anything that directly benefits the recipients, such as requirements of quality care or equal access. Moreover, it is

> at least unclear that the actuarial soundness provision is intended to create a right for providers to a certain reimbursement rate. It is equally plausible that the section is intended to protect the State plan from overpayment.

Clayworth, 295 F.Supp.2d at 1124 (internal citations and quotations omitted). Furthermore, the Actuarial Soundness Provision completely lacks rights-creating language. The provision has an aggregate focus on the State's methods of setting rates, rather than on whether the needs of particular individuals have been satisfied. *See Gonzaga*, 536 U.S. at 273-75, 122 S.Ct. 2268 (finding that the provisions in question did not contain the requisite rights-creating language because "they are not concerned with whether the needs of any particular person have been satisfied") (internal quotations omitted). Therefore, the Court finds that the Actuarial Soundness Provision does not confer a federal right upon any of the plaintiffs.

I. Cognizable Supremacy Clause Claim[51]

Plaintiffs allege that HHSC's setting of low payment rates violates the Supremacy Clause in that the rates are inconsistent with specific provisions of the Medicaid Act. To remedy these inconsistencies, Plaintiffs seek

51. As discussed above, Plaintiffs only have standing to assert a claim that HHSC's implementation of HB1 violates the Supremacy Clause. *See supra* Part II(E) (determining that Plaintiffs' lack standing to claim that HB1 itself violates the Supremacy Clause in that it conflicts with the Medicaid Act).

relief "under 42 U.S.C. § 1983." Pls.' First Am. Compl., at 26, ¶ 64. However, "[t]he Supremacy Clause, of its own force, does not create rights enforceable under § 1983." *Golden State,* 493 U.S. at 104-5, 110 S.Ct. 444. Therefore, to the extent Plaintiffs seek to remedy the alleged Supremacy Clause violation through § 1983, Plaintiffs must allege violations of a federal right. The only federal right Plaintiffs have established is based on the Equal Access Provision.[52] Thus, Plaintiffs only cognizable Supremacy Clause claim under § 1983 is one asserting that the Equal Access Provision[53] violates the Supremacy Clause. This Supremacy Clause claim is functionally equivalent to Plaintiffs' claim under § 1983 discussed earlier.[54] Therefore, there is no need to further analyze this claim.

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52. *See supra* Part III(B)-(H) (concluding that Plaintiffs' only assert a cognizable claim under the Equal Access Provision of the Medicaid Act).

53. Plaintiffs could also theoretically assert that HHSC's actions violate the Comparability Provision or the Reasonable Promptness Provision through a § 1983 claim. However, as discussed above, Plaintiffs do not state a cognizable claim under the Comparability Provision or the Reasonable Promptness Provision that would require a Supremacy Clause analysis. *See supra* Part III(D),(G) (explaining that Plaintiffs do not state a cognizable claim pursuant to the Comparability Provision or the Reasonable Promptness Provision).

54. *See supra* Part III(B) (determining that Recipient Plaintiffs state a cognizable claim under the Equal Access Provision).

In addition, Plaintiffs' complaint arguably states an *Ex Parte Young* cause of action in that Plaintiffs are suing for prospective relief against state officials in their official capacity for an ongoing violation of federal law. *AT & T Commc'ns v. BellSouth Telecomm. Inc.*, 238 F.3d 636, 647 (5th Cir.2001) ("Under the Ex parte Young doctrine, a private party may sue individual state officers in federal court to obtain prospective relief from an ongoing violation of federal law"). Such a claim could be functionally distinct if it afforded relief for violations of provisions of the Medicaid Act that the Court did not find to create a federal right enforceable under § 1983. However, the Court finds that the Supreme Court would be unlikely to recognize a claim that state *action* violates a federal law absent an express statutory right of action, either under the Medicaid Act or under § 1983. *See Alexander v. Sandoval*, 532 U.S. 275, 121 S.Ct. 1511, 149 L.Ed.2d 517 (2001) (refusing to recognize a claim that Alabama's policy of administering its driver's license examinations only in English violated federal regulations promulgated under Title VI because Congress did not intend to confer a private right of action to enforce the regulations); *see also* Davis Sloss, *Constitutional Remedies for Statutory Violations*, 89 Iowa L.Rev. 355, 358 (2004) (explaining that in "cases in which private plaintiffs sue state officers to enjoin state executive action that allegedly violates a federal statute .... the [Supreme Court] does not address the merits of plaintiff's claim unless the plaintiff can establish an express statutory private right of action, either under the federal statute that creates the substantive right, or under § 1983"). Therefore, Plaintiffs do not state a

cognizable claim under the Supremacy Clause that is distinct from their § 1983 claim pursuant to the Equal Access Provision.[55] Thus, functionally, Plaintiffs state only one cognizable claim, a claim that HHSC's payment rates violate the Equal Access Provision.

J. Cognizable Equal Protection Clause Claim

Count eight of Plaintiffs' complaint alleges that "Defendant's practices and procedures for administering Medicaid services in El Paso County, Texas violate the 14th Amendment of the U.S. Constitution in that individuals in El Paso County who are enrolled in Medicaid are not treated equally by HHSC when compared to other individuals in the State of Texas." Pls.' First Am. Compl., at 26, ¶ 66. Specifically, Plaintiffs allege that "Medicaid recipients in El Paso receive much less funding per-person than does the average Medicaid recipient in Texas." *Id.*

The Equal Protection Clause of the Fourteenth Amendment requires that all similarly situated persons be treated substantially alike. *Plyler v. Doe*, 457 U.S. 202, 216, 102 S.Ct. 2382, 72 L.Ed.2d 786 (1982). The Fifth Circuit has stated that "when state welfare statutes are challenged under the equal protection clause, they are subject to examination only for some rational relationship to a proper state end, an examination

55. An *Ex Parte Young* claim does not offer relief unavailable to a § 1983 claimant. Therefore, it is not necessary to treat Plaintiffs' possible *Ex Parte Young* claim as distinct from Plaintiffs' § 1983 claim.

minimally exacting." *Curtis v. Taylor*, 625 F.2d 645, 650 (5th Cir.1980). However, "that does not automatically render such challenges frivolous. State welfare regulations must have a rational basis for the distinctions they draw." *Id.* Additionally, the Court should proceed to consider the merits of Equal Protection claims unless "prior decisions inescapably render the claims frivolous." *Id.* at 649-50.

Plaintiffs' Equal Protection claims are two-fold. First, Plaintiffs claim that Medicaid recipients in El Paso do not receive the same level of service as recipients in other parts of the state. Second, Plaintiffs claim that Medicaid providers in El Paso are paid lower capitation rates than providers in other parts of the state. With respect to Plaintiffs' first claim, Plaintiffs admit that the "Medicaid fee schedules are in effect Statewide." Pls.' First Am. Compl., at 3, ¶ 3. In Plaintiffs' own words, "if a physician in El Paso performs a simple delivery of a baby, she is reimbursed the same under the Medicaid fee schedules as a physician in Houston who performs the identical procedure." *Id.* Similarly, with respect to Plaintiffs' second claim, Plaintiffs do not challenge HHSC's assertion that it uses the same formula for setting capitation rates throughout Texas, a formula based on the cost and utilization of services in a geographic area. *See supra* note 1 (explaining how HHSC calculates capitation rates). Plaintiffs do not challenge HHSC's methodology in setting capitation rates based on the cost and utilization of services. Basing capitation rates on the costs and utilization of services is clearly rationally related to the state's objective of providing medical services.

Therefore, Plaintiffs admit that HHSC administers Medicaid in El Paso using the identical methods it uses throughout the state. Assuming Plaintiffs could meet their burden of establishing an Equal Protection violation, Plaintiffs appear to request that the Court fashion a remedy that would require HHSC to treat El Paso *more favorably* than the rest of the state, presumably by instituting higher fee schedules and more favorable capitation formulas for El Paso than for the rest of the state. Not only do Plaintiffs fail to state a claim under the Equal Protection Clause, but the implementation of Plaintiffs' requested relief very well might create an Equal Protection issue, given the difference in fee schedules and capitation formulas.[56] Thus, Plaintiffs' alleged facts do not state a cognizable claim under the Equal Protection Clause.

K. Declaratory Judgment Relief

Defendant claims that Plaintiffs are not entitled to a declaratory judgment because "Plaintiffs have not established an actionable right under any other law." Original Mot. to Dismiss, at 16. Plaintiffs are correct that

56. For example, if doctors in Houston were paid less for the performance of identical services, they might be able to claim that HHSC has no rational basis for this unequal treatment. Similarly, if HHSC used a capitation formula more favorable to El Paso Medicaid recipients, Medicaid recipients in other regions might be able to bring a claim that compensating providers beyond what the cost and utilization of services warrants has no rational relationship to the state's purpose of providing medical services.

the Declaratory Judgment Act does not create an independent cause of action. *Bauhaus USA, Inc. v. Copeland*, 292 F.3d 439, 448 n. 11 (5th Cir.2002) (citing favorably the proposition that in passing the Declaratory Judgment Act, "Congress enlarged the range of remedies available in the federal courts but it did not extend their subject-matter jurisdiction") (citing 10B Charles Alan Wright, Arthur R. Miller, & Mary Kay Kane, Federal Practice and Procedure § 2766 (3d ed.1998)). However, as explained above, the Court finds that Recipient Plaintiffs have stated a cognizable claim under the Equal Access Provision of the Medicaid Act. Therefore, Plaintiffs have stated a proper claim pursuant to the Declaratory Judgment Act.

IV. PRINCIPLES OF JUDICIAL ADMINISTRATION—THE *FREW* CLASS

Defendant argues that principles of judicial administration require the Court to find that Plaintiff-children's claims are barred by the ongoing case *Linda Frew, et al. v. Albert Hawkins, et al.*, No. 3:93-CV-65 (E.D.Tex. Sept. 1, 1993). The *Frew* case is a class action challenging the adequacy of HHSC's provision of Early, Periodic, Screening, Diagnosis and Treatment ("EPSDT") services to young Medicaid recipients. Am. Mot. to Dismiss, Frew-3rd Am. Compl., at 2, ¶ 2. The *Frew* class consists "of all present and future Texas Medicaid recipients who are under the age of 21, and therefore eligible for EPSDT services, but who have not received the entire range of EPSDT services to which they are entitled." Am. Mot. to Dismiss, Frew-Order of 6/16/94.

Appendix B

In the case of *Gillespie v. Crawford*, 858 F.2d 1101 (5th Cir.1988), Gillespie filed a suit for equitable relief from allegedly unconstitutional Texas prison conditions. The Fifth Circuit held that Gillespie's equitable claims were barred by the orders and pendency of *Ruiz v. Estelle*, 503 F.Supp. 1265 (S.D.Tex.1980), a class action which "challenged successfully the constitutionality of conditions at prisons operated by [the Texas Department of Corrections]." *Gillespie*, 858 F.2d at 1102. The *Ruiz* class was "composed of all past, present and future inmates confined by the Texas Department of Corrections." *Id.* Subsequent to *Ruiz*, a Fifth Circuit panel in *Green v. McKaskle*, 770 F.2d 445, 446-47 (5th Cir.1985), held that individual class members should be barred from pursuing lawsuits that seek equitable relief "within the subject matter" of the *Ruiz* class. In agreement with the *Green* panel, the *Gillespie* court held that Gillespie's claims were barred for the following reasons:

> Permitting multiple courts to entertain equitable claims and issue decrees that might affect the Texas prison system would require other courts to become familiar with the *Ruiz* decree, the current problems of the Texas prison system, and the possible disruptive effect of the exercise of equitable powers over matters covered by the *Ruiz* decree. Moreover, if separate suits for equitable relief are filed in other districts than that in which *Ruiz* is pending, even with respect to problems not encompassed by the relief granted in *Ruiz*,

> the court's orders may hobble the effect of the *Ruiz* court's continuing decree over the Texas prison system and its power both to enforce and to modify that decree.

Gillespie, 858 F.2d at 1103.

Unlike in *Gillespie,* Plaintiff-children's claims are not within the subject matter of the *Frew* class. The *Frew* class does not allege claims under any of the Medicaid provisions pursuant to which Plaintiffs sue in the instant case. Specifically, the *Frew* class does not assert a violation of the Equal Access Provision, the only provision pursuant to which Plaintiffs have asserted a cognizable claim. Moreover, the *Frew* class challenges the methods and procedures through which HHSC administers EPSDT, but it does not appear to challenge the adequacy of Medicaid payment rates. Plaintiffs' sole surviving challenge in the instant case is to the adequacy of Medicaid payment rates. Therefore, evaluating the instant case does not require the Court to familiarize itself with the *Frew* decree, nor has Defendant shown how the Court's decision could interfere with the *Frew* case. Thus, Plaintiff-children's claims are not barred by principles of judicial administration as a result of the *Frew* class.

V. CERTIFICATION FOR INTERLOCUTORY APPEAL

Defendant requests that the Court certify this case for interlocutory appeal pursuant to 28 U.S.C. § 1292 ("§ 1292"). Section 1292(b) states the following:

> When a district judge, in making in a civil action an order not otherwise appealable under this section, shall be of the opinion that such order involves a controlling question of law as to which there is substantial ground for difference of opinion and that an immediate appeal from the order may materially advance the ultimate termination of the litigation, he shall so state in writing in such order. The Court of Appeals which would have jurisdiction of an appeal may thereupon, in its discretion, permit an appeal to be taken from such an order, if application is made to it within ten days after the entry of the order. . . .

The Court is of the opinion that all three statutory requirements have been met. *See Aparicio v. Swan Lake*, 643 F.2d 1109, 1111 (5th Cir.1981) ("Section 1292(b) sets out three criteria all of which must be met before the district court may properly certify an interlocutory order for appeal."). Specifically, there is ground for a difference of opinion with respect to the following controlling questions of law: (1) whether Recipient Plaintiffs have

standing to bring any of their claims;[57] and (2) whether the Equal Access Provision of the Medicaid Act confers a private right of action upon Recipient Plaintiffs. Either a finding that Recipient Plaintiffs lack standing or that the Equal Access Provision does not confer a private right of action upon Recipients Plaintiffs would dispose of the case. Furthermore, the Court finds it likely that the Fifth Circuit will decide that the Equal Access Provision does not confer a private right of action upon Recipient Plaintiffs in light of the decision of the Supreme Court in *Gonzaga*. Therefore, it would be an improper use of judicial resources and the resources of the parties to proceed with the case before these aforementioned questions of law are decided. Thus, this case should be certified for interlocutory appeal to the Court of Appeals for the Fifth Circuit.

VI. CONCLUSION

To summarize, the Court finds that both Recipient Plaintiffs and Provider Plaintiffs have standing to assert their claims under the Medicaid Act. Plaintiff Equal Access has associational standing to sue on behalf of its member Medicaid recipients and providers, but Provider Plaintiffs do not have third-party standing to sue on behalf of their patients and members. Plaintiffs also have standing to assert their Supremacy Clause claim to the extent they challenge HHSC's implementation of

57. In particular, it is a close question whether Recipient Plaintiffs have standing in light of the allegation that their injuries are a result of El Paso's unique payor mix, an independent factor not caused by HHSC's conduct.

Medicaid in El Paso. However, the only cognizable claim under the Medicaid Act is Recipient Plaintiffs' claim under the Equal Access Provision. Plaintiffs also state a claim under the Supremacy Clause that is functionally equivalent to their Equal Access Provision claim pursuant to § 1983, but they do not state a claim under the Equal Protection Clause. The Court also holds that principles of judicial administration do not compel the Court to bar the claims of Plaintiff-children as a result of the *Frew* case.

In the final analysis, only one claim remains: Recipient Plaintiffs' claim that HHSC's low payment rates violate the Equal Access Provision of the Medicaid Act. Even this sole remaining claim stands on uncertain ground because it is likely that the Fifth Circuit will decide that Congress did not intend the Equal Access Provision to confer a private right of action upon Medicaid recipients in light of the more stringent requirements of *Gonzaga*. Therefore, the Court finds it appropriate to certify this case for interlocutory appeal to the Court of Appeals for the Fifth Circuit for the resolution, in its discretion, of the legal issues presented in this opinion.

Accordingly, **IT IS ORDERED** that Defendant's Motion to Dismiss (Docket No. 57) is **GRANTED IN PART** and **DENIED IN PART**.

IT IS FURTHER ORDERED that the above-captioned cause is certified for interlocutory appeal to the Court of Appeals for the Fifth Circuit and that either

party may appeal this case to the Court of Appeals for the Fifth Circuit within ten days of the entry of this order.

IT IS FINALLY ORDERED that the above-captioned cause is **STAYED** pending resolution by the Court of Appeals for the Fifth Circuit.

SIGNED this 30th day of March, 2006.

s/ Philip R. Martinez
PHILIP R. MARTINEZ
UNITED STATES DISTRICT JUDGE

APPENDIX C — PLAINTIFFS' FIRST AMENDED COMPLAINT FILED JUNE 24, 2004

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
EL PASO DIVISION

CIVIL ACTION NO. EP-03-CA-0440-PRM

EQUAL ACCESS FOR EL PASO, INC.; EL PASO COUNTY HOSPITAL DISTRICT d/b/a R.E. THOMASON GENERAL HOSPITAL; EL PASO FIRST HEALTH PLANS, INC.; JOSE LUNA, JR., M.D.; MONICA RIVERO AS NEXT FRIEND OF KEVIN RIVERO; PATRICIA DUARTE MELENDEZ, IN HER INDIVIDUAL CAPACITY AND AS NEXT FRIEND OF ORANDIE JAHSSAR MELENDEZ-DUARTE AND OSNAR JOSHUA MELENDEZ (AKA by Medicaid "OZNAR MELENDEZ); JESSILYN NAGEL AS NEXT FRIEND HEIDI ARMSTRONG AND McKENNA ARMSTRONG; RUTH GALLEGOS, IN HER INDIVIDUAL CAPACITY AND AS NEXT FRIEND OF AMBER VILLEGAS,

Plaintiffs,

v.

ALBERT HAWKINS, COMMISSIONER OF THE TEXAS HEALTH AND HUMAN SERVICES COMMISSION, IN HIS OFFICIAL CAPACITY,

Defendant.

PLAINTIFFS' FIRST AMENDED COMPLAINT

Appendix C

TO THE HONORABLE JUDGE OF SAID COURT:

COME NOW Plaintiffs, Equal Access for El Paso, Inc. ("Equal Access"); El Paso County Hospital District d/b/a R.E. Thomason General Hospital (the "Hospital District"); El Paso First Health Plans, Inc. ("El Paso First"); Jose Luna, Jr., M.D.; Monica Rivero as next friend of Kevin Rivero; Patricia Duarte Melendez, in her individual capacity and as next friend of Orandie Jahssar Melendez-Duarte and Osnar Joshua Melendez (AKA by Medicaid "Oznar Melendez"); Jessilyn Nagel as next friend of Heidi and McKenna Armstrong; and Ruth Gallegos, in her individual capacity and as next friend of Amber Villegas complaining of Albert Hawkins, Commissioner of the Texas Health and Human Services Commission, in his official capacity, and would show the Court as follows:

I.

INTRODUCTION

1. This is an action against a Texas State official arising out of his failure to comply with various provisions of the Medicaid Act, 42 U.S.C. § 1396 *et. seq.* and applicable rules and regulations. Plaintiffs seek declaratory and injunctive relief to address these violations of federal law that effectively deny Medicaid recipients in El Paso County, Texas access to appropriate medical care and services, as required by federal law.

2. Among other issues, Defendant spends significantly less per-capita for Medicaid acute care services delivered in the geographic region in which Plaintiffs reside than in other geographic regions of Texas. Medicaid recipients in El Paso receive services that are less in amount, duration and scope than received by similarly situated Medicaid recipients in other parts of the state. The Texas Medicaid program is financed with a combination of state and federal dollars whereby $1 of state funds is "matched" by approximately $2 of federal funds. This match rate varies by state and is driven by a state's average per-capita income relative to other states; the "poorer" the state, the better the match. So, the Defendant reaps the benefit of the poverty of El Paso County, yet spends a disproportionate amount of Medicaid funds in other parts of the state. This is not equitable. This is not a recent phenomenon; in fact, it has been the norm since the beginning of the Texas Medicaid program.

3. Under the traditional Medicaid "fee-for-service" program, which is run parallel to the Medicaid managed care program, physicians and other health care professionals are reimbursed based on fee schedules established by Defendant. The Medicaid fee schedules break down hundreds of different procedures into discreet "codes," which in turn are each assigned a monetary value. The Medicaid fee schedules are in effect Statewide. For example, if a physician in El Paso performs a simple delivery of a baby, she is reimbursed the same under the Medicaid fee schedules as a physician in Houston who performs the identical procedure. The

problem is that these professional service rate schedules, particularly those for physician services, dental services and therapy services, are woefully inadequate, particularly for a community like El Paso wherein Medicaid is a major payor for health care services. These inadequate fee schedules are forcing health care professionals such as physicians, dentists and therapists to curtail their participation in Medicaid or drop out of the program completely and therefore are not sufficient to enlist sufficient providers such that the same amount, duration and scope of care and services are available to Medicaid recipients as are available to the general population. Because professionals have been forced to reduce their level of service to the program, the payments do not promote and are not consistent with efficient, economic or quality care. Because professionals have been forced to reduce their level of service to the program, medical assistance is not being delivered with reasonable promptness.

4. This problem is not limited to just the traditional Medicaid fee-for-service program. Under the Medicaid managed care program, the capitation rates paid to participating HMOs are set with the assumption that health care professionals like physicians will be paid the Medicaid fee-schedule, more or less. The Medicaid managed care capitation rates set by Defendant in the geographic area in which Plaintiffs reside are significantly lower than other similarly situated areas, and are well below the statewide average. Thus, the capitation rates perpetuate all of the same inequities and problems identified in the preceding two paragraphs.

Finally, because the capitation rates are set to perpetuate the inadequate professional fee schedule, they are not actuarially sound.

5. To add insult to injury, the 78th Texas Legislature has set a two-year budget that anticipates a 2.5 percent reduction to Medicaid rates paid to health care professionals, like physicians, dentists and therapists under their fee schedules, and to participating HMOs.

6. The disproportionately low per-capita expenditures, the low managed care capitation rates, the discrepancy in the level of services compared to other parts of the state, and the wholly inadequate Medicaid fee schedules have forced health care providers to significantly curtail their participation in Medicaid or drop out of the program completely. This negatively impacts the Medicaid recipients' access to services and violates a host of federal laws. This is true for services accessed under both the Medicaid fee-for-service program and the Medicaid managed care program.

II.

JURISDICTION AND VENUE

7. This Court has subject matter jurisdiction under 28 U.S.C. § 1331, which confers on the federal district courts original jurisdiction over all civil suits arising under the Constitution and laws of the United States, and under 28 U.S.C. § 1343(a)(3) and (4), which confer on the federal district courts original jurisdiction over

all claims asserted under 42 U.S.C. § 1983 to redress any deprivation, under color of state law, of rights, privileges, and immunities guaranteed by the Constitution of the United States and the Acts of Congress.

8. Plaintiffs' request for declaratory and injunctive relief, and for other appropriate equitable relief, is authorized by 28 U.S.C. §§ 2201-02, 42 U.S.C. § 1983, 28 U.S.C. § 1331, and Fed. R. Civ. Proc. 52 and 65.

9. Venue is proper in the Western District of Texas under 28 U.S.C. § 1391(b).

III.

PARTIES

10. Plaintiff Equal Access for El Paso, Inc. ("Plaintiff Equal Access") is a Texas not-for-profit corporation located in El Paso County, Texas composed of individuals interested in the provision of health care in El Paso, including Medicaid beneficiaries. The purpose of Plaintiff Equal Access is to develop health care resources and access to health care in El Paso County. Plaintiff Equal Access has no parent corporation, and, because it issues no stock, no publicly held corporation owns 10 percent or more of its stock. Plaintiff Equal Access brings this action on behalf of its members, many of whom are Medicaid recipients and health care professionals and other providers who are directly and adversely impacted by the Defendant's actions, and on

behalf of the its member health care professionals' and providers' patients.

11. Plaintiff El Paso County Hospital District d/b/a R.E. Thomason General Hospital ("Plaintiff District") is a county hospital district doing business in El Paso County, Texas. Plaintiff District was created pursuant to Article IX, § 4 of the Texas Constitution and formed under Chapter 281 of the Texas Health & Safety Code. It is charged with providing health care services to El Paso's indigent population. Plaintiff District owns and operates, among other things, R.E. Thomason Hospital, a large urban hospital that serves thousands of Medicaid recipients, Plaintiff El Paso First Plans, Inc., and Thomason Cares, Inc., a health organization certified to provide physician services by the Texas State Board of Medical Examiners that also serves thousands of Medicaid recipients. Plaintiff District employs many health care professionals. Plaintiff District brings this action on its own behalf and on behalf of its Medicaid recipient patients because they are directly and adversely affected by the actions of the Defendant.

12. Plaintiff El Paso First Health Plans, Inc. ("Plaintiff HMO") is a health maintenance organization ("HMO") licensed by the State of Texas and doing business in El Paso County, Texas. Plaintiff HMO is a Texas not-for-profit corporation. It has no parent corporation; rather, its sole member is the El Paso County Hospital District. Because it issues no stock, no publicly held corporation owns 10 percent or more of its stock. Plaintiff HMO serves several thousand Medicaid

recipients. Plaintiff HMO brings this action on its own behalf and on behalf of its Medicaid recipient enrollees because they are directly and adversely affected by the actions of the Defendant.

13. Plaintiff Jose Luna, Jr., M.D. ("Plaintiff Dr. Luna") is a Board-Certified Family Physician who resides in El Paso County, Texas. Plaintiff Dr. Luna serves hundreds of Medicaid recipients. Plaintiff Dr. Luna brings this action on his own behalf and on behalf of his Medicaid recipient patients because they are directly and adversely affected by the actions of the Defendant.

14. Plaintiff Monica Rivero and her child, Kevin Rivero, are Medicaid recipients residing in El Paso County, Texas.

15. Plaintiff Patricia Duarte Melendez and her children, Orandie Jahssar Melendez-Duarte and Osnar Joshua Melendez (AKA by Medicaid "Oznar Melendez) are Medicaid recipients residing in El Paso County, Texas. Plaintiff Patricia Melendez brings this action on her own behalf and as the next friend of her two children, Orandie and Osnar.

16. Plaintiff Jessilyn Nagel and her children, Heidi and McKenna Armstrong, are Medicaid recipients residing in El Paso County, Texas. Plaintiff Jessilyn Nagel brings this action on her own behalf and as the next friend of her two children, Heidi and McKenna.

17. Plaintiff Ruth Gallegos and her child, Amber Villegas, are Medicaid recipients residing in El Paso County, Texas. Plaintiff Ruth Gallegos brings this action on her own behalf and as the next friend of her child, Amber.

18. Defendant Albert Hawkins is the Commissioner of the Texas Health and Human Services Commission, and is sued in his official capacity. Defendant Hawkins is served with this amended complaint through his attorney of record.

IV.

STATUTORY AND REGULATORY FRAMEWORK

19. In 1965, Congress enacted Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et. seq.*, establishing Medicaid, a medical assistance program cooperatively funded by federal and state governments (the "Medicaid Act"). Medicaid is designed to ensure that low-income Americans receive necessary medical services. The purpose of the Medicaid Act is to furnish medical assistance for families with dependent children, disabled individuals, and others whose income and resources are insufficient to meet the costs of necessary medical services.

20. The Centers for Medicare and Medicaid Services ("CMS") of the United States Department of Health and Human Services is the agency that administers Medicaid at the federal level. 42 C.F.R. Part 30 sets forth rules

and guidelines that govern CMS, which are binding on all states that participate in Medicaid. While a state's participation in Medicaid is voluntary, once a state elects to participate, it must adhere to the federal requirements set forth in the Medicaid Act and applicable rules and regulations. Texas has chosen to participate in Medicaid. The Defendant official is responsible under the Medicaid Act and under state law for implementing the program in accordance with the requirements set forth in the Medicaid Act, its regulations, and CMS' policy.

21. A participating state is required to adopt a plan that is consistent with the requirements of the Medicaid Act. The Medicaid Act provides that the provisions of the state Medicaid Plan become mandatory upon participation and must be in effect in all political subdivisions of the state. 42 U.S.C. § 1396a(a)(1); 42 C.F.R. § 431.50. Texas has designated the Texas Health and Human Services Commission as the single State agency responsible for the administration of the state Medicaid plan pursuant to 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10. *See also* Tex. Gov't Code Chapters 531 and 533.

22. When a state accepts Medicaid funds, federal law mandates that the state must ensure:

a. that payment rates are consistent with efficiency, economy, and quality of care, and are sufficient to enlist enough providers so that care and services are available under the plan at least to the

extent that such care and services are available to the general population in the geographic area. 42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. § 447.204;

b. that the medical assistance made available to any beneficiary is not less in amount, duration, or scope than the medical assistance made available to either any other Medicaid beneficiaries, or other individuals. 42 U.S.C. § 1396a(a)(10)(B); 42 C.F.R. §§ 440.230 and 449.240;

c. that it provides for financial participation equal to all of the non-federal share of the expenditures under the plan or provides for distribution of funds from federal or state sources, for carrying out its plan on an equalization or other basis that will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. 42 U.S.C. § 1396a(a)(2);

d. that it provides that the plan shall be in effect in all political subdivisions of the State, and that the plan will be in operation statewide through a system of local offices, under equitable standards for assistance in administration that are mandatory throughout the state. 42 U.S.C. § 1396a(a)(1); 42 C.F.R. § 431.50(b)(1); and

e. that it provides that medical assistance under the plan shall be furnished with reasonable promptness to all eligible individuals. 42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.930.

23. In addition, in order for a state to receive federal funds for payments determined responsible for the provision of in-patient hospital under a prepaid capitation basis or under any other risk basis for services provided by any entity and certain other services, the contract between the state and the managed care organization must establish prepaid payments that are made on an actuarially sound basis. 42 U.S.C. § 1396b(m)(2)(A)(iii).

V.

FACTS

24. The "Medicaid Recipient Plaintiffs" (Patricia Duarte Melendez and her children, Monica Rivero and her children, Jessilyn Nagel and her children, and Ruth Gallegos and her children), depend on Medicaid for medical assistance. Each has experienced difficulties in accessing medical assistance in a manner inconsistent with the requirements of federal Medicaid law.

25. Patricia Duarte Melendez has experienced long waits in her physician's office to obtain dermatological services. Patricia Duarte Melendez's children, Orandie Jahssar Melendez-Duarte and Osnar Joshua Melendez, have medical conditions requiring treatment from a

variety of healthcare professionals, including primary care and specialist physicians and therapists of all kinds. Ms. Melendez has been frustrated in that her children must wait days, weeks and sometimes months for appointments with physicians and therapists. She and her children have been forced to endure long waiting periods in health care providers' offices. Sometimes her children require medical and therapeutic services that are unavailable to her in El Paso from a Medicaid provider. She has been forced to seek services in Dallas on behalf of one child, where such services are readily available for Medicaid recipients. Ms. Melendez's problems stems from lack of physicians and therapists in the El Paso area, the lack of physicians and therapists willing to accept Medicaid, and the number of physicians and therapists who have had to curtail their participation in Medicaid. All of these problems result from the extremely low payment schedules under Medicaid. The healthcare services the Melendez family receives are not consistent with efficiency, economy or quality of care. The services they receive are not reasonably prompt. Women and children in El Paso covered by traditional insurance have better access to healthcare than Ms. Melendez or her children. Similarly situated Medicaid recipients in other parts of the State have better access to medical assistance in comparison to Ms. Melendez and her children.

26. Ruth Gallegos had difficulty locating a gynecologist, and when she finally succeeded, she was forced to endure an inordinately long wait to obtain an appointment with the physician. Ms. Gallegos has been frustrated in that her child, Amber Villegas, must wait

days, weeks and sometimes months for appointments with physicians and dentists. She and her child have been forced to endure long waiting periods in health care providers' offices. Ruth Gallegos has had to consider seeking medical care for her child, in Juarez, Mexico because of the length of time it has taken to see a primary care physician and locate a dentist willing to accept Medicaid patients under the age of five in the El Paso area. The Gallegos' problems stem from the lack of physicians and dentists in the El Paso area, the lack of physicians and dentists willing to accept Medicaid, and the number of physicians and dentists who have had to curtail their participation in Medicaid. All of these result from the extremely low payment schedules under Medicaid. The healthcare services they receive are not consistent with efficiency, economy or quality of care. The services they receive are not reasonably prompt. Women and children in El Paso covered by traditional insurance have better access to healthcare than Ms. Gallegos or her child. Similarly situated Medicaid recipients in other parts of the State have better access to medical assistance in comparison to Ms. Gallegos and her child.

27. Similar to the others, Jessilyn Nagel has been faced with frustration in obtaining medical services for her children, Heidi and McKenna Armstrong. Of most concern to Ms. Nagel is the fact that the specialist who treated Heidi's gastric problems as a newborn has since relocated, and physicians with similar qualifications do not exist in El Paso should Heidi require further care. Ms. Nagel has been frustrated in that her children

must wait days, weeks and sometimes months for appointments with physicians and therapists. She and her children have been forced to endure long waiting periods in health care providers' offices. The Nagel's problems stem from the lack of physicians and therapists in the El Paso area, the lack of physicians and therapists willing to accept Medicaid, and the number of physicians and therapists who have had to curtail their participation in Medicaid. These all result from the extremely low payment schedules under Medicaid. The healthcare services they receive are not consistent with efficiency, economy or quality of care. The services they receive are not reasonably prompt. Women and children in El Paso covered by traditional insurance have better access to healthcare than Ms. Nagel or her children. Similarly situated Medicaid recipients in other parts of the State have better access to medical assistance in comparison to Ms. Gallegos and her children.

28. Monica Rivero's child, Kevin A. Rivero, has significant medical needs requiring treatment from primary care and specialist physicians. Many of the procedures needed by Kevin have been performed in Dallas because of the lack of specialists and specialty facilities necessary to accomplish these procedures in El Paso. Due to the lack of specialty physicians in the El Paso area, Ms. Rivero has found it impossible to obtain the medical services Kevin needs in El Paso. Ms. Rivero has been frustrated in that her child must wait days, weeks and sometimes months for appointments with physicians and therapists. She and her child have been forced to endure long waiting periods in health care

providers' offices. The Rivero's problems stem from the lack of physicians and therapists in the El Paso area, the lack of physicians and therapists willing to accept Medicaid, and the number of physicians and therapists who have had to curtail their participation in Medicaid. These all result from the extremely low payment schedules under Medicaid. The healthcare services they receive are not consistent with efficiency, economy or quality of care. The services they receive are not reasonably prompt. Women and children in El Paso covered by traditional insurance have better access to healthcare than Ms. Rivero or her children. Similarly situated Medicaid recipients in other parts of the State have better access to medical assistance in comparison to Ms. Rivero and her child.

29. The problems presented by the Medicaid Recipient Plaintiffs are faced by most Medicaid recipients in El Paso. Medicaid rates are so low that physicians, therapists and dentists in El Paso have been forced to curtail their participation in the Medicaid program in favor of participating in higher paying health programs. Consequently, men, women and children in El Paso covered by traditional insurance have far better access to healthcare professionals such as physicians, therapists and dentists than those covered by Medicaid. Other parts of the state that enjoy greater per-capita numbers of healthcare professionals also enjoy more contact with healthcare professionals for services. Moreover, people in need of care provided by pediatric sub-specialist physicians and other specialty professionals are forced to seek that care in areas such

as Lubbock, Fort Worth, Austin, Dallas or Houston, because such specialists elect not to practice in El Paso. El Paso lacks pediatric gastroenterologists, pediatric nephrologists, pediatric thoracic surgeons and developmental pediatricians. This is also due to the low Medicaid reimbursement rates. So, similarly situated Medicaid recipients in other parts of Texas receive services that are more in amount, duration and scope than the services made available to El Paso's Medicaid recipients. Unfortunately, the vast majority of these Medicaid recipients do not have access to the level of information necessary to assert their rights, and even if they did have such information, they lack resources to assert their rights. Plaintiff Equal Access was formed to develop health care resources and equal access to health care in El Paso County. It has members who are Medicaid recipients who face the same types of problems and inequities faced by the Medicaid Recipient Plaintiffs. Plaintiff Equal Access brings this action on behalf of its members, many of whom are Medicaid recipients and health care professionals and other providers who are directly and adversely impacted by the Defendant's actions, and on behalf of the its member health care professionals' and providers' patients because it furthers the organization's mission, its member's would otherwise have standing to sue in their own right, and neither the claims asserted or the relief requested requires the participation of individual members in the lawsuit.

30. Plaintiff District and Plaintiff Dr. Luna provide medical services to Medicaid recipients for reimbursement rates that are inadequate. Practitioners,

such as Plaintiff Dr. Luna, are incapable of serving the existing Medicaid population in El Paso, and few physicians and other providers are willing to relocate to El Paso for that reason. Because of the low rates, El Paso physicians have curtailed or eliminated their Medicaid practices, so Plaintiff Dr. Luna's Medicaid recipient patients are deprived of their right to receive safe, timely and adequate medical care and encounter difficulties and inequities similar to those of the Medicaid Recipient Plaintiffs and other El Paso Medicaid recipients as more fully described in the preceding paragraphs. Likewise, Plaintiff District is a county district created pursuant to Article IX, § 4 of the Texas Constitution and formed under Chapter 281 of the Texas Health & Safety Code. It is charged with providing health care services to El Paso's indigent population. Plaintiff District owns and operates, among other things, R.E. Thomason Hospital, a large urban hospital, Plaintiff HMO and a physician organization that services its clinics. Plaintiff District, through the healthcare professionals it either employs directly or through other entities, provides medical and other healthcare services to thousands of Medicaid recipients. Because of the low per-capita Medicaid expenditures in El Paso County, the Plaintiff District is unable to provide services to its Medicaid recipient patients as described more fully in the preceding paragraphs and that are consistent with efficiency, economy and quality. Plaintiff District's Medicaid recipient patients face the same types of problems and inequities as the Medicaid Recipient Plaintiffs and other El Paso Medicaid recipients, as described in the preceding paragraphs, and it is due to

the low Medicaid reimbursement rates paid to healthcare professionals. Both Plaintiff Dr. Luna and Plaintiff District are suing on behalf of themselves and on behalf of their Medicaid recipient patients because the vast majority of their Medicaid recipient patients do not have access to the level of information necessary to assert their rights, and even if they did have such information, they lack the resources to assert their rights.

31. Plaintiff HMO, is a provider of managed care services to the Texas Medicaid program. Because of Defendant's actions, the capitation rates paid to El Paso First are inadequate to develop the kind of provider base necessary to ensure that Medicaid recipients have access to Medicaid services equivalent to that of non-Medicaid recipients. Its Medicaid members have encountered the same kinds of problems and inequities identified in the preceding paragraphs due to these low capitation rates. Moreover, the capitation rates mandated by Defendant to be paid to Plaintiff HMO are not actuarially sound. Plaintiff HMO is suing on behalf of itself and on behalf of its Medicaid recipient members because the vast majority of its Medicaid recipient members do not have access to the level of information necessary to assert their rights, and even if they did have such information, they lack the resources to assert their rights.

32. The next several paragraphs explain how the actions of the Defendant have caused the plight of the Plaintiffs and the Medicaid recipient patients of Plaintiffs Dr. Luna, Plaintiff District and Plaintiff HMO. Per capita expenditures of funds on Medicaid recipients in the geographic area encompassing El Paso County, Texas are

significantly lower than the statewide average. The Medicaid capitation rates set by Defendant in this geographic area are significantly lower than other similarly situated areas, and are well below the statewide average. Moreover, because of these low capitation rates, participating managed care organizations are unable to pay providers much more than amounts paid under the Medicaid fee-for-service program. The Medicaid fee-for-service rates in effect in Texas are far below the usual and customary fees charged by most providers. Because of these low reimbursement rates, providers are unwilling to participate in Medicaid, resulting in insufficient access to needed medical services. Indeed, the Defendant identified this problem in the December 20, 2000, Border Rate Workgroup Report. That report demonstrated that El Paso fell below the statewide average for Medicaid for in- and out-patient admissions per thousand, in- and out-patient days per thousand, average PMPM in-and out-patient payments, professional visits per thousand, professional services per thousand and average PMPM payment for professional services. Thus, Medicaid recipients in El Paso, under fee-for-service, were found to receive services that were less in scope, amount and duration than similarly situated Medicaid recipients in other parts of the State. The report found that reduced revenues, compared to the state as a whole, provides a disincentive for health care providers to locate and remain in the Texas-Mexico border region, and that the low number of providers and the lack of pediatric specialty hospitals in the border areas consequently results in low utilization of services, further driving down revenues. The Defendant is ultimately responsible for ensuring that the services received by Medicaid recipients in El Paso County, like the Medicaid

Recipient Plaintiffs and the patients and members of the other Plaintiffs, are not less in amount, scope and duration as other similarly situated Medicaid recipients in other parts of the state. The Defendant's failure to fulfill such responsibility violates federal Medicaid law.

33. Beginning in 1991, the State of Texas began to utilize managed care for Medicaid acute care services in urban areas in Texas. From 1991 to 1999, Defendant implemented Medicaid managed care in Austin, San Antonio, Fort Worth, Lubbock, and Houston. In 1999, Defendant implemented Medicaid managed care in Dallas and in the "El Paso Service Area," encompassing Culberson, Hudspeth and El Paso Counties.

34. To establish the capitation rates paid to participating Health Maintenance Organizations in the various service areas scattered across the State, Defendant broke the Medicaid recipient population down into discreet "risk groups" based on age and criteria for admission into Medicaid, looked at the average Medicaid per-capita fee-for-service expenditures in each risk group for a set number of years preceding implementation of managed care, and discounted this average expenditure in order to establish the capitation rates paid to participating Health Maintenance Organizations. Simply put, the more the State spent per-capita in a particular geographic area prior to implementation of managed care, the more the State would spend in that region in the future. Those parts of the State, like El Paso, that had the misfortune of low per-capita expenditures in the past continue to suffer the consequences of low managed care capitation rates.

Appendix C

35. The following chart relates the capitation rates by risk group in each service area in Texas in State Fiscal Year 2000:

SFY 2000 Medicaid Managed Care Rates

	TANF Adults	TANF Children	Mandate Children	Newborns	Pregnant Women	Expansion Children	C.H.I.P. (Phase I)	Wghtd Average
Bexar	171.50	60.71	42.39	415.11	592.89	67.32	77.81	137.41
El Paso	146.51	71.39	46.74	360.31	594.26	90.63	73.46	138.04
Lubbock	193.57	75.72	51.93	417.65	560.76	64.88	86.18	143.73
Dallas	155.91	68.09	55.72	322.45	646.38	136.73	99.35	149.27
Tarrant	187.16	75.97	50.84	477.64	621.93	96.73	83.54	160.24
Harris	188.64	78.75	51.97	586.10	648.91	100.40	94.83	176.64

Source: Texas Department of Health

As demonstrated by the chart, the lowest capitation rates paid in the State in 1999 were in El Paso and San Antonio. This trend continues to date, as demonstrated by the following chart:

SFY 2003 Medicaid Managed Care Rates

	TANF Adults	TANF Children	Mandate Children	Newborns	Pregnant Women	Expansion Children	C.H.I.P. (Phase I)	Wghtd Average
Bexar	203.94	83.22	55.19	436.33	586.02	74.42	78.42	158.04
El Paso	196.73	97.83	48.69	450.99	550.28	86.28	68.99	135.20
Lubbock	229.53	100.74	67.84	432.66	512.10	77.02	96.63	159.79
Dallas	220.96	91.45	57.92	471.65	606.80	111.48	79.86	175.51
Tarrant	228.77	99.68	68.86	493.31	613.19	100.77	98.08	203.91
Harris	225.78	105.79	67.51	634.21	614.23	117.57	96.10	207.78
All Pilots	217.21	97.04	61.91	520.83	597.20	104.40	86.24	184.79

Source: Texas Department of Health

So, the Defendant continues to perpetuate the historic reimbursement policies through managed care that in turn drive down access to care, and the other problems and inequities identified in the preceding paragraphs, for Medicaid recipients in El Paso with respect to similarly situated Medicaid recipients in other parts of the State and with respect to privately insured individuals receiving care in El Paso. The Defendant is ultimately responsible for ensuring that the services received by Medicaid recipients in El Paso County, like the Medicaid Recipient Plaintiffs and the patients and members of the other Plaintiffs, are not less in amount, scope and duration as other similarly situated Medicaid recipients in other parts of the state. The Defendant's actions therefore violate federal Medicaid law.

36. In addition, Defendant has failed to set actuarially sound rates in that he has failed to provide routine rate increases to account for medical inflation and increasing administrative burdens. According to the Bureau of Labor Statistics, medical inflation hit a "low" in late 1997 of about 3 percent, and has risen steadily since. In July 2003, medical care inflation was reported to be 3.9 percent. More telling is the sharp increase in employer sponsored health insurance premiums. The rate of inflation of such premiums hit a "low" in 1996 of about 8 percent. In 2003, the Bureau of Labor Statistics reports premium increases in excess of 13 percent per year, and anticipates that this trend will continue. Since the inception of Medicaid managed care in El Paso, capitation rate increases have lagged far behind these increases. The Defendant is ultimately responsible for

setting the Medicaid capitation rates paid to Plaintiff HMO. These actions violate federal Medicaid law.

37. Not all Medicaid acute care services delivered in the El Paso Service Delivery Area are provided under a managed care model. For example, individuals who qualify for Medicaid by virtue of being eligible for Supplemental Security Income ("SST") have their services paid for under the Medicaid fee-for-service system.

38. Moreover, both state and federal governments provide funding for Medicaid. State funds are "matched" by federal funds as determined by a State's Federal Matching Assistance Percentage ("FMAP"). Texas' FMAP for Fiscal Year 2003 is estimated to be 60.17, meaning that every $.40 of State funding is matched by $.60 of federal money (approximately). The Texas Legislature appropriated approximately $25 billion for Medicaid for State Fiscal Years 2002-2003. Obviously, even slight changes to Texas' FMAP have significant repercussions on the amount of federal matching funds Texas will receive. FMAPs are established by CMS based on a statutorily created formula that benefits states with a high amount of poverty relative to the national average. The 15 Texas counties bordering Mexico, including El Paso, are among the poorest in the United States. This abject poverty allows Texas to receive higher federal matching funds for Medicaid, but the disproportionate share of the funding goes to non-border counties. The Defendant is ultimately responsible for apportioning Medicaid funds throughout the state. The Defendant's actions therefore violate federal Medicaid law.

Appendix C

39. The inequitable and inadequate funding for the provision of services to Medicaid recipients is primarily due to a lack of commitment by the Texas Legislature to appropriate sufficient funds to the Medicaid program. The Legislature must pass a budget that finances State operations for two state fiscal years (a biennium). The Legislature passes these budgets in the form of various appropriations acts. The 78th Texas Legislature passed during its Regular Session, as House Bill 1, the current biennium's budget covering the period September 1, 2003 to August 31, 2005. Line items B.2.1. through B.2.8. of the Medicaid budget, which sets forth appropriations made to the Health and Human Services Commission, are most pertinent to this lawsuit. Faced with a potential budget shortfall of approximately $10 billion, the 78th Legislature, as part of its plan to balance the budget, mandated that the already inadequate fees be cut by 2.5 percent. The Defendant is ultimately responsible for implementing these Acts of the Legislature by setting the Medicaid budget for the Texas Health and Human Services Commission, the state agency responsible for managing the Medicaid program in Texas. The Defendant has overseen the budget cuts. These actions violate federal Medicaid law.

40. Because of historically inadequate funding, Medicaid rates paid to physicians lag significantly behind Medicaid fees (anywhere from 40 percent to 70 percent) and private insurance (approximately 50 percent). These discrepancies are particularly damaging when viewed in the context of the so-called "payor mix" in El Paso, as compared to other Texas counties. According to the 2000

census, El Paso County had approximately 680,000 residents. Approximately 32 percent of these residents had employer-sponsored insurance. Medicaid covered another 16 percent. A full 35 percent of residents were uninsured. In contrast, counties similar in size to El Paso County have far better payor mixes. For example, Travis County had approximately 810,000 residents in 2000; about 69 percent of which were covered with employer-sponsored insurance, 5 percent by Medicaid, and 18 percent uninsured.

41. What this means is that a physician who practices in El Paso County relies on Medicaid as a source of payment to a much greater extent than a physician who practices in Travis County. Thus, to the extent there is a significant financial advantage to practicing in areas with higher private insurance coverage, physicians have a financial disincentive to practice in El Paso County. Simultaneously, the El Paso physician has a far greater financial incentive to serve a person covered by employer-sponsored insurance than does the Travis County physician because any reduction to the El Paso physician's Medicaid caseload that is accompanied by an increase in private insurance income produces a proportionately greater financial gain.

42. Thus, the payor mix, in conjunction with the discrepancy in fees paid under Medicaid versus other payor sources, creates a financial incentive for physicians to practice in communities such as Travis County, and creates a disproportionate financial incentive to physicians practicing in El Paso County to seek out

patients covered by employer-sponsored insurance. This ultimately results in reduced access to physician services for Medicaid recipients in El Paso compared to the rest of the State and as compared to individuals covered by private insurance in El Paso itself. The Defendant ultimately sets the rates paid to Medicaid providers and HMOs. The rates perpetuate the problems and inequities of the Plaintiffs and the Medicaid recipient patients and members of the other Plaintiffs. These acts of the Defendant violate federal Medicaid laws.

VI.

CAUSES OF ACTION

Count 1:
Denial of Equal Access and Quality of Care

43. The allegations in Paragraphs 1 through 40 are incorporated herein as if fully set forth.

44. Defendant's practices and procedures for administering services for Medicaid beneficiaries in El Paso County, Texas violate 42 U.S.C. § 1396a(a)(30)(A) and 42 C.F.R. § 447.204. More specifically, the Medicaid capitation and reimbursement rates set by Defendant in the geographic area in which the Plaintiff Medicaid beneficiaries reside are not sufficient to enlist enough providers so that care and services are available to them at least to the extent that such care and services are available to the general population in this geographic area.

45. In addition, the Medicaid capitation and reimbursement rates established by Defendant are not consistent with efficiency, economy, and quality of care. Specifically, Defendant has neither provided nor assured that payments to providers in this geographic area are consistent with the preventive purposes of the program (efficiency), or with the timely delivery of preventive care in the avoidance of avoidable high cost chronic conditions and crisis care and higher cost environments (economy), or with quality of care.

46. This violation of Plaintiffs' federal rights by Defendant in his official capacity entitles Plaintiffs to relief under 42 U.S.C. § 1983. In addition, Plaintiffs seek declaratory relief pursuant to 28 U.S.C. § 2201 and Fed. R. Civ. P. 57 in that Defendant's conduct violates Plaintiffs' rights under the Medicaid Act and its implementing rules and regulations.

Count 2:
Denial of Equal Treatment and Comparable Care

47. The allegations in Paragraphs 1 through 40 are incorporated herein as if fully set forth.

48. Defendant's practices and procedures for administering services for Medicaid beneficiaries in El Paso County, Texas violate 42 U.S.C. § 1396a(a)(10)(B) and the implementing regulations, 42 C.F.R. § 440.230 and 440.240. More specifically, medical assistance made available to Plaintiffs and other Medicaid recipients in El Paso County are less in amount, duration, and scope

than the medical assistance made to Medicaid beneficiaries and other individuals in other geographical areas.

49. This violation of Plaintiffs' federal rights by Defendant in his official capacity entitles Plaintiffs to relief under 42 U.S.C. § 1983. In addition, Plaintiffs seek declaratory relief pursuant to 28 U.S.C. § 2201 and Fed. R. Civ. P. 57 in that Defendant's conduct violates Plaintiffs' rights under the Medicaid Act and its implementing rules and regulations.

Count 3:
Failure to Equalize Funding

50. The allegations in Paragraphs 1 through 40 are incorporated herein as if fully set forth.

51. Defendant's practices and procedures for administering Medicaid services in El Paso County, Texas violate 42 U.S.C. § 1396a(a)(2). More specifically, the Medicaid plan distributes state and federal medical assistance funding in such a manner that the lack of adequate funds from local sources in the El Paso region results in a lowering of the amount, duration, scope and quality of care and services made available under the plan to Plaintiffs.

52. This violation of Plaintiffs' federal rights by Defendant in his official capacity entitles Plaintiffs to relief under 42 U.S.C. § 1983. In addition, Plaintiffs seek declaratory relief pursuant to 28 U.S.C. § 2201 and

Fed. R. Civ. P. 57 that Defendant's conduct violates Plaintiffs' rights under the Medicaid Act and its implementing rules and regulations.

Count 4:
Failure to Operate the Plan Statewide under Equitable Standards

53. The allegations in Paragraphs 1 through 40 are incorporated herein as if fully set forth.

54. Defendant's practices and procedures for administering Medicaid services in El Paso County, Texas violate 42 U.S.C. § 1396a(a)(1) and the implementing regulation, 42 C.F.R. § 431.50(b)(1). More specifically, Defendant failed to operate and administer the State plan under equitable standards that are mandatory throughout the State. The poverty level in the fifteen Texas counties that border Mexico, including El Paso, benefits the State by allowing Texas to receive a higher amount of federal funding by virtue of Texas' FMAP. Defendant's administration of the State plan in a way that provides for a disproportionate share of federal funding to non-border counties violates the federal requirement that the plan be operated statewide under equitable standards for assistance and administration that are mandatory throughout the State. It is inequitable for the State to benefit from the poverty level in El Paso County, which maximizes the amount of federal funding received by the State, while failing to ensure that the Medicaid recipients in El Paso receive proper and timely services through appropriate funding in this area.

55. This violation of Plaintiffs' federal rights by Defendant in his official capacity entitles Plaintiffs to relief under 42 U.S.C. § 1983. In addition, Plaintiffs seek declaratory relief pursuant to 28 U.S.C. § 2201 and Fed. R. Civ. P. 57 in that Defendant's conduct violates Plaintiffs' rights under the Medicaid Act and its implementing rules and regulations.

Count 5:
Failure to Ensure Reasonably Prompt Medical Assistance

56. The allegations in Paragraphs 1 through 40 are incorporated herein as if fully set forth.

57. Defendant's practices and procedures for administering Medicaid services in El Paso County, Texas violate 42 U.S.C. § 1396a(a)(8) and the implementing regulation, 42 C.F.R. § 435.930. More specifically, medical assistance made available to Plaintiffs and other Medicaid recipients in El Paso County is not furnished with reasonable promptness to all eligible individuals.

58. This violation of Plaintiffs' federal rights by Defendant in his official capacity entitles Plaintiffs to relief under 42 U.S.C. § 1983. In addition, Plaintiffs seek declaratory relief pursuant to 28 U.S.C. § 2201 and Fed. R. Civ. P. 57 in that Defendant's conduct violates Plaintiffs' rights under the Medicaid Act and its implementing rules and regulations.

Appendix C

Count 6:
Managed Care; Lack of Actuarial Soundness of Rates

59. The allegations in Paragraphs 1 through 40 are incorporated herein as if fully set forth.

60. Defendant's practices and procedures for administering services for Medicaid beneficiaries through contracts with managed care organizations violate 42 U.S.C. §1396b(m)(2)(A)(iii). More specifically, Defendant failed to establish capitation rates on an actuarially sound basis.

61. This violation of Plaintiffs' federal rights by Defendant in his official capacity entitles Plaintiffs to relief under 42 U.S.C. § 1983. In addition, Plaintiffs seek declaratory relief pursuant to 28 U.S.C. § 2201 and Fed. R. Civ. P. 57 in that Defendant's conduct violates Plaintiffs' rights under the Medicaid Act and its implementing rules and regulations.

Count 7:
Violation of the Supremacy Clause

62. The allegations in Paragraphs 1 through 40 are incorporated herein as if fully set forth.

23. House Bill 1 of the 78th Texas Legislature (the General Appropriations Act) and Defendant's regulations, policies, practices and procedures for administering Medicaid services in El Paso County,

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Texas violate the Supremacy Clause of the U.S. Constitution in that they are inconsistent with, and violate:

a. 42 U.S.C. § 1396a(a)(30)(A) and 42 C.F.R. § 447.204, which require the Medicaid capitation and reimbursement rates set by Defendant in the geographic area in which the Plaintiff Medicaid beneficiaries reside to be sufficient to enlist enough providers so that care and services are available to them at least to the extent that such care and services are available to the general population in this geographic area;

b. 42 U.S.C. § 1396a(a)(10)(B), 42 C.F.R. § 440.230 and 440.240, which require the medical assistance made available to Plaintiffs and other Medicaid recipients in El Paso County be equal in amount, duration, and scope than the medical assistance made available to Medicaid beneficiaries and other individuals in other geographical areas;

c. 42 U.S.C. § 1396a(a)(2), which requires that the Medicaid plan distribute state and federal medical assistance funding in such a manner that the lack of adequate funds from local sources in the El Paso region do not result in a lowering of the amount, duration, scope and quality of care and services made available under the plan to Plaintiffs;

d. 42 U.S.C. § 1396a(a)(1) and 42 C.F.R. § 431.50(b)(1), which require the Defendant to operate and administer the State plan under equitable standards that are mandatory throughout the State;

e. 42 U.S.C. § 1396a(a)(8) and 42 C.F.R. § 435.930, which require the medical assistance made available to Plaintiffs and other Medicaid recipients in El Paso County to be furnished with reasonable promptness to all eligible individuals; and

f. 42 U.S.C. § 1396b(m)(2)(A)(iii), which requires Defendant to establish capitation rates on an actuarially sound basis.

64. This violation of the U.S. Constitution by Defendant in his official capacity entitles Plaintiffs to relief under 42 U.S.C. § 1983. In addition, Plaintiffs seek declaratory relief pursuant to 28 U.S.C. § 2201 and Fed. R. Civ. P. 57 in that Defendant's conduct violates Plaintiffs' rights under the U.S. Constitution.

Count 8:
Violation of the 14th Amendment to the U.S. Constitution

65. The allegations in Paragraphs 1 through 40 are incorporated herein as if fully set forth.

66. Defendant's practices and procedures for administering Medicaid services in El Paso County, Texas violate the 14th Amendment of the U.S. Constitution in that individuals in El Paso County who are enrolled in Medicaid are not treated equally by Defendant when compared to other individuals in the State of Texas. Medicaid recipients in El Paso receive much less funding per-person than does the average Medicaid recipient in Texas.

67. This violation of the U.S. Constitution by Defendant in his official capacity entitles Plaintiffs to relief under 42 U.S.C. § 1983. In addition, Plaintiffs seek declaratory relief pursuant to 28 U.S.C. § 2201 and Fed. R. Civ. P. 57 in that Defendant's conduct violates Plaintiffs' rights under the U.S. Constitution.

VII.
COSTS AND ATTORNEY'S FEES

68. Plaintiffs seek their costs and reasonable attorney's fees pursuant to 42 U.S.C. § 1988.

VIII.
JURY DEMAND

69. Plaintiffs assert their rights under the Seventh Amendment to the U.S. Constitution and demand, in accordance with Federal Rule of Civil Procedure 38, a trial by jury on all issues.

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IX.
REQUEST FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that this honorable court grant the following relief:

1. issue a declaratory judgment that Defendant's conduct set forth above violates Plaintiffs' rights under the Medicaid Act, 42 U.S.C. § 1396 *et. seq.*, and its implementing rules and regulations, all in violation of Article IV of the U.S. Constitution, the 14th Amendment to the U.S. Constitution, and 42 U.S.C. § 1983;

2. enter a preliminary and, upon final hearing, a permanent injunction enjoining Defendant, its agents, successors, and employees from failing to comply with the federal and state statutes, rules and regulations outlined above; more specifically:

    a. enjoin Defendant from setting Medicaid capitation and reimbursement rates in the geographic area encompassing El Paso, Texas insufficient to enlist enough providers so that care and services are available to Plaintiffs at least to the extent that such care and services are available to the general population, and require Defendant to set sufficient capitation and reimbursement rates;

b. enjoin Defendant from establishing Medicaid capitation and reimbursement rates inconsistent with efficiency, economy, and quality of care, and require Defendant to establish appropriate and sufficient capitation and reimbursement rates in this geographic area;

c. require Defendant to ensure that medical assistance is made available to Plaintiffs and other Medicaid beneficiaries in this geographic area that are not less in amount, duration, or scope than the medical assistance made available to Medicaid beneficiaries and other individuals in other geographical areas;

d. require Defendant to provide for the distribution of funds from federal and state sources for carrying out its Medicaid plan on an equalization or other basis that would assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

e. require Defendant to operate and administer the State plan under equitable standards that are mandatory throughout the State;

f. require Defendant to ensure that medical assistance is made available to Plaintiffs and other Medicaid beneficiaries in this geographic area with reasonable promptness;

g. require Defendant to establish capitation rates for services provided by an entity responsible for the provision of in-patient hospital and certain other services that are made on an actuarially sound basis;

h. require Defendant to comply with applicable federal laws and regulations so that adequate and high quality health care may be made available to all children and adults who need the care and are not financially able to pay for it; and,

i. require Defendant to amend the Medicaid program's contract with Plaintiff El Paso First so that it provides for capitation and provider payment rates that ensure the cost-effective provision of quality health care;

3. award Plaintiffs their reasonable costs and attorneys fees, including expert witness fees; and

4. grant such other and further relief to which Plaintiffs may show themselves entitled.

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PLAINTIFF EQUAL ACCESS FOR EL PASO, INC.'S DISCLOSURE STATEMENT

Plaintiff Equal Access for El Paso, Inc. ("Equal Access") files this Disclosure Statement pursuant to FRCP 7.1, and offers the following information in support thereof:

Equal Access is a Texas not-for-profit corporation. It has no parent corporation. Because it issues no stock, no publicly held corporation owns 10 percent or more of its stock.

PLAINTIFF EL PASO FIRST HEALTH PLANS, INC.'S DISCLOSURE STATEMENT

Plaintiff El Paso First Health Plans, Inc. ("El Paso First") files this Disclosure Statement pursuant to FRCP 7.1, and offers the following information in support thereof:

El Paso First is a Texas not-for-profit corporation. It has no parent corporation; rather, its sole member is the El Paso County Hospital District. Because it issues no stock, no publicly held corporation owns 10 percent or more of its stock.

Respectfully submitted,

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